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:	Individualised Services
Name of provider:	St Christopher's Services Company Limited by Guarantee
Address of centre:	Longford
Type of inspection:	Unannounced
Date of inspection:	19 September 2023
Centre ID:	OSV-0008405
Fieldwork ID:	MON-0038834

About the designated centre

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

The centre comprises two house, one located in Longford town and one located in Legan village. Both houses are bungalows and provide individualised services to one resident each. The centre can meet the needs of two residents, both male and female, with moderate to severe to profound intellectual disabilities, complex needs, sensory needs and behavioural needs. Residents are supported by social care workers and support workers under the governance of a person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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 19 September 2023	10:10hrs to 18:45hrs	Karena Butler	Support

What residents told us and what inspectors observed

Overall, from what the inspector was told and what was observed, this inspection found good quality care and support was being provided to residents. However, significant improvements were required in relation to fire precautions and further improvements were required in written polices and procedures, training and staff development, premises, governance and management, risk management procedures and medicines and pharmaceutical services. These areas are discussed further in the next sections of the report.

This centre was made up of two houses within driving distance of one another. The provider had made an application to register a third house within the designated centre and the inspector also visited that house during this inspection. Each house that made up the centre catered for one resident to have an individualised service with one-to-one staffing. The inspector met with the two residents that lived in the centre and the resident for the third proposed house on the day of the inspection.

The two current residents used the properties as their base for their individualised day programme and day service staff would come to the person's home and provide the service. On the day of inspection, one resident completed a weekly resident's meeting then went for a drive and a walk in a garden centre. The resident in house two went swimming and then went for a walk in a park followed by coffee out. Upon return to the centre they helped prepare their dinner with staff and then played on their games console.

Upon entering each premises the houses appeared tidy and for the most part clean however, the inspector noted there was slight mildew observed in an area of two of the houses. There was sufficient space for privacy and recreation for residents. There were suitable in-house recreational equipment available for use, such as televisions, art supplies, sensory objects and DVDs, depending on the residents' preferences. Each resident had their own bedroom and there were adequate storage facilities for their personal belongings. Two residents had an en-suite facility. Residents' rooms had personal pictures and items displayed. House two had the resident's own artwork displayed in their bedroom and a carved wooden man that they had made was displayed in the back garden. House one had an art room which the resident displayed some of their own artwork.

In addition to the person in charge, there was one staff member on duty during the day of the inspection in each of the houses. The person in charge and the staff members spoken with demonstrated that they were very familiar with the residents' care and support needs and preferences. They were observed to engage with residents in a manner that was respectful and not rushed. Residents appeared relaxed and comfortable in the presence of staff. A staff member was observed using sign language as well as verbal communication in order to communicate with a resident.

The person in charge had arranged for staff to have training in human rights. One staff spoken with said that the training helped them become a stronger advocate for the resident when communicating the resident's will and preference.

The next two sections of this report present the findings of this inspection in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being provided.

Capacity and capability

This inspection was undertaken following the provider's granted application of registration of the centre in order to assess if they were operating within compliance with the S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations). This was the first inspection of this centre since its registration in December 2023.

This inspection found that the provider and person in charge were operating the centre in a manner that ensured residents were in receipt of a service that was person-centred.

The provider had prepared in writing, adopted, and implemented policies and procedures as per Schedule 5 of the regulations. However, the Garda vetting policy was overdue for review since March 2023. Additionally, some policies were coming up to their review date with no evidence demonstrated that they would be reviewed within the prescribed timescale.

There was a defined management structure in place. The person in charge was employed in a full time capacity and had the necessary experience and qualifications to fulfil the role.

The provider arranged for local audits and reviews conducted in areas such as finance, medication management, and infection prevention and control. However, not all areas identified on this inspection were identified by the provider in particular in relation to fire precautions.

The inspector observed that there was a planned and actual roster in place. A review of the rosters demonstrated that the staffing and skill mix were appropriate to the assessed needs of the residents. However, not all staff that worked from within the centre supporting residents were identified on the centres rosters.

There were established supervision arrangements in place for staff. In addition, the provider had ensured staff had access to training and development opportunities in order to carry out their roles effectively. However, the oversight document for staff training needs could not fully be relied upon as not all dates were correct and not all training completed by staff was accounted for on the document. Furthermore, not

all refresher training was found to be in date and there were long gaps between when some training was due and when it was refreshed.

The provider had suitable arrangements in place for the management of complaints. There had been a low level of complaints in the centre and any complaints made had been suitably recorded, investigated and resolved.

Regulation 14: Persons in charge

The person in charge was employed in a full time capacity and had the necessary experience and qualifications to fulfil the role. They demonstrated a good very good knowledge of the residents' needs.

Judgment: Compliant

Regulation 15: Staffing

There was a planned and actual roster maintained by the person in charge. Staffing levels and skill mix were effective in meeting residents' assessed needs.

Staff personnel files were not reviewed as part of this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

There were formalised supervision arrangements in place and the person in charge provided supervision to the residential staff team.

Staff had access to necessary training and development opportunities. For example, staff had completed training on fire safety and hand hygiene training. Additionally, staff were trained in human rights. Further details on this have been included in what residents told us and what inspectors observed section of the report.

However, the training matrix was found to not be fully accurate in all training provided for staff and dates recorded. From evidence provided on the day of the inspection not all applicable training was completed by all staff, for example two staff required training in standard and transmission-based precautions (contact, droplet and airborne), including the appropriate use of personal protective equipment (PPE) for each situation. In addition, while one staff from house one was provided with training on safeguarding it was not evident if they had safeguarding

training that included training on the national policy.

Additionally, not all refresher training was within prescribed time frames. For example:

- two staff were due refresher training in donning and doffing PPE
- management of behaviours that challenge training was recorded as expired since November 2022 for one day service staff in a house were a resident may display behaviours of distress that required staff support and for another day service staff their training was expired in January 2023
- administration of medication training for one day service staff expired in December 2022 and although they were scheduled to complete this training in the coming weeks after the inspection in the meantime the staff was lone working with a resident
- two day service staff and one residential staff required first aid training as their training was expired in either March or June 2023. The person in charge confirmed that the residential staff member was completing this training on the day of the inspection.

Judgment: Not compliant

Regulation 23: Governance and management

There was a defined management structure in place which included the person in charge and the residential and respite manager who was the person participating in management for the centre.

The provider arranged for local audits and reviews conducted in areas, such as finance, medication management and health and safety. However, as discussed under fire safety in section 2 of this report, the provider's own auditing systems had not picked up on some of the issues identified on the day of the inspection, therefore this required review.

In addition, day service staff who worked from each of the houses were not accounted for on the rosters of the centre. These staff worked in the centre supporting the residents with their day programs and it was not evident if the person in charge had full oversight of this. Those staff reported into a manager of the day service and that manager provided their formal supervision and monitored their training needs. Therefore, it was not clear how the person in charge was ensuring that staff received their training and formal supervision as required as evidenced under Regulation 16: Training and staff development.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was a complaints policy, and associated procedures in place. There was a designated complaint officer nominated. There was one recent complaint made and it had been suitably recorded, investigated and resolved.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider had prepared in writing, adopted, and implemented policies and procedures as per Schedule 5 of the regulations.

A number of policies were recently reviewed. However, the Garda vetting policy was overdue for review since March 2023 and a few of policies were due for review in September 2023 with no evidence of them in draft format in order to assure they would be reviewed within prescribed time frames.

Judgment: Substantially compliant

Quality and safety

The inspector found that the residents received a good quality of care and support in their home. It was evident that staff members had a good level of knowledge of residents' support needs. However, significant improvement was required in relation to fire precautions and some improvements were required in relation to premises, risk management procedures and medicines and pharmaceutical services.

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place which was for the most part serviced within suitable time frames as required. However, the layout of house two meant that a number of rooms were inner rooms and therefore not exiting out onto a protected hallway in order to promote safe egress. In addition, a number of doors across the three houses would not close fully by themselves. Furthermore, a self-closing device was required for one fire containment door of the house that the provider was looking to register as part of this designated centre. In house two there was an over reliance on door keys being available in the event of an emergency.

Residents' needs were assessed and there were personal plans in place for any identified needs including healthcare needs and staff were familiar with residents' support needs. Appropriate healthcare was made available to each resident, for

example, a nurse or general practitioner (G.P).

The inspector reviewed the arrangement in place to support residents' positive behaviour support needs. The person in charge was found to be promoting a restraint free environment, and while there was one restrictive practice in place in once house, a sensor mat, it was used for the resident's safety.

In addition, where necessary, residents received specialist support to understand and alleviate the cause of any behaviours that may put them or others at risk. Furthermore, there were systems in place to safeguard residents. There was evidence that incidents were appropriately managed.

The inspector found that there were adequate mechanisms in place to uphold residents' rights. For example, there were weekly residents' meetings and residents were offered choices or provided food and activities based on their preferences.

From a walkabout of the centre the inspector found the houses to have adequate space and they were laid out to meet the needs of the residents. However, the garden of house one required to be further developed to appropriately meet the resident's needs and preferences. The houses were very tidy and generally clean. However, house two required works to be completed with regard to rising damp and some areas required repair, replastering and or repainting. In addition, some slight mildew was observed in both houses and the storage of mops and buckets required review to ensure adequate drying was promoted.

There were arrangements in place to manage risk, including an organisational policy and associated procedures. The centre had a risk register and risk assessments in place with regard to the centre and individual risk assessments for residents. However, the provider had not risk assessed the use of the utility room as an area to cook some food or store and or prepare medicines to ensure that the risk of cross contamination had been mitigated.

Medicines were found to be ordered, received and stored appropriately. Residents' medicines were prescribed by appropriate medical professionals, and dispensed by a pharmacist. However, not all prescribed medication had a pharmacy label. In addition, while residents had a capacity assessment completed in the area of self-administration of their medication a risk assessment was not completed.

Regulation 17: Premises

Each premises was found to be tidy and for the most part clean. Each premises had an adequate sized back garden. However, the garden in house one was not currently fully suitable for the resident's needs as it was mostly made up of grass other than a small pathway and the resident's preference was not to walk on grass. The person in charge communicated that there were plans to make a section of the garden into a patio and a sensory area; however, at the time of this inspection there

were no concrete plans or dates for this.

There was rising damp self-identified in house two and the provider had arranged for a review by a competent person to take place in May 2023. The provider gave written assurances to the inspector on the day of the inspection that works would be completed on the property by December 2023. A number of areas required replastering, and or repainting, for example the external doors of the property and the sitting room floor required repair or replacement. The inspector was assured that any required work would be completed once the rising damp issue was rectified.

The inspector observed that there was slight mildew along the window frame of the resident's bedroom in house two and in the washing machine detergent drawer in house one. Mops and buckets were not stored correctly in the houses. For example, the mops were stored in the buckets which would lead in inadequate drying and could promote bacterial growth.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Risk management arrangements ensured that for the most part risks were identified, monitored and regularly reviewed. There was a policy on risk management available and the centre had a risk register in place.

In addition, the boilers for the two properties were serviced within the last year and from review of a sample of the centre's vehicles it demonstrated that they were taxed and insured. The vehicle observed did not require a national car test (NCT) at the time of the inspection due to the age of the car.

However, the use of the utility room as an area to store and or prepare medicines or cook some food in as well as do laundry had not been risk assessed to ensure that the risk of cross contamination had been mitigated.

Judgment: Substantially compliant

Regulation 28: Fire precautions

For the most part there were suitable fire safety management systems in place, including detection and alert systems, emergency lighting and fire-fighting equipment, each of which for the most part were regularly serviced within recommended time frames. However, house two's layout meant that a number of rooms were inner rooms and the bedroom doors were not fire containment doors. This meant that in order to exit in the event of a fire that a person would have to

exit out through another room before gaining access to a protected hallway that led out of the building. At the time of this report the provider had arranged for a competent fire person to review the property and they suggested some alterations to enhance the fire containment measures of the building and means of escape. The provider was reviewing their options following this review at the time of this report.

In addition, a number of doors across the three houses would not close fully by themselves. A self-closing device was required for one door of the proposed house three.

House two, did not have emergency lighting outside of one emergency exit at the front of the property and there was an over reliance on keys being available for escape in the event of an emergency.

Additionally, while fire evacuation drills were regularly completed they did not include practicing different scenarios that could take place in the event of a fire. For example, from documentation provided it appeared that residents only practiced exiting though their front doors.

Furthermore, an outbuilding that was close to house three and would be used by staff members and the resident was not connected to the fire detection alert system.

The inspector had a query as to the level of coverage of the alarm type that was in operation in house two in order to ensure it provided appropriate detection. The provider submitted assurances to the inspector in the days after the inspection with assurances that the alarm coverage was suitable for the building.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

For the most part the person in charge ensured that there were appropriate and suitable practices relating to the ordering, receipt, prescribing, storage, disposal, and administration of medicines. However, not all medication had a pharmacy label attached in order to ensure medication was taken as prescribed.

There were some residents self-administering medicine and the centre had conducted an assessment of capacity for residents; however, no risk assessment was conducted for residents in relation to this.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents' health, personal and social care needs were assessed and there were personal plans in place for any identified needs.

Judgment: Compliant

Regulation 6: Health care

Residents were supported with their healthcare needs and appropriate healthcare was made available to each resident. Residents had access to a G.P, and a range of allied health professionals, such as a psychologist and a dietician. Referrals were made as required for any additional reviews. For example, a referral was made for a resident to have a speech and language review.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge was promoting a restraint free environment. There was one restrictive practice in use and it was in place for the resident's safety, was subject to periodic review and a log of its use kept.

Where residents presented with behaviour that challenged, the provider had arrangements in place to ensure these residents were supported and a behaviour support plan was in place and reviewed as required by an appropriate person.

Judgment: Compliant

Regulation 8: Protection

There were arrangements in place to protect residents from the risk of abuse, including an organisational policy and clear procedures. There was an identified designated officer, and it was found that concerns or allegations of potential abuse were investigated and reported to relevant agencies.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector found that there were adequate mechanisms in place to uphold residents' rights. For example, there were weekly residents' meetings taking place to try to establish what the resident might like to do for the week or what they may like to eat. Staff demonstrated that they understood the residents' communication methods and were observed respectfully communicating with them. In addition, a staff member was observed respecting a resident's wishes that they were communicating thought their behaviour, for example communicating when they wanted to leave the centre.
Judgment: 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	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Individualised Services OSV-0008405

Inspection ID: MON-0038834

Date of inspection: 19/09/2023

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff have now completed all outstanding training. Going forward staff will be rostered to attend training prior to their current certificate expiring. A formal quarterly meeting will be held between PIC and day service unit head, where PIC will seek assurances that day staff are in certificate for training	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Additions have been made to the policy and Procedure on the Provision of day services in residential designated centers. These additions include a formal quarterly meeting between PIC and day service unit head, where assurance will be sought on the status of staff training and staff supervision. Day service staff are now included on the residential service off duty. A review of internal audit on fire safety has been completed and communicated to all staff via each registered PIC.	

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The Garda vetting policy was reviewed and circulated in May 2023, this is available on share point for staff to access. A printed hard copy is now available in schedule 5 folder.
All policies due for review in September has been completed, and are for BOD sign off on 23/10/2023

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Plans for sensory garden to be developed and quotations sought for same. Works to be completed by 30/06/2024.
All issues with rising damp have been actioned, however given the additional fire works that is required at this property, a full planning application is being lodged as the property is a listed heritage building. If planning application successful, works will be complete by 30/04/2024
All mildew has been removed from window sill, and the cleaning of same has been added to daily cleaning checklist.
The mop that was stored in the mop bucket has been replaced with a flat mop with removable head- which is to be washed in the washing machine after each use.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
A risk assessment of the utility room in house 1 has not shown a high risk of cross contamination due to medication press being stored in this area of the house. The air fryer is stored in the utility room, however it is moved to the kitchen for all food preparation and cooking

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
House 3- outbuilding is now fully covered by fire detection alarm system. Door closure has been placed on remaining door. All doors were checked by maintenance and fire company and are closing fully.This action is complete.
House 1- All doors were checked by maintenance and fire company and are closing fully. Staff are submitting assurances weekly of same following bell test checks.
House 2- A full planning application is being developed to submit to the local council, as this property is a listed heritage building, the application is for works relating to fire safety- to create an exit directly from bedroom 3, to replace all internal doors with 30 minute fire doors and for the remedial works needed to alleviate the rising damp identified. If planning application successful, works will be complete by 30/04/2024.
Two external door locks will be replaced with thumb locks. This action will be completed by 20/10/2023.
The staff sleepover bedroom will transfer to the office space and the office will move to the previous staff bedroom. This action will be completed by 27/11/2023.
One additional fire door will be installed between resident bedroom and the living room, this door will have a full length glass panel- it will allow resident a protected space on exiting their bedroom to assess which escape route to take in the event of a fire evacuation. This door will be installed by 27/10/2023.
Staff are to ensure fire drills simulate fires in various locations in each house and practice leaving via alternative routes.
The additional emergency light required at one entrance will be installed and commissioned by 03/11/2023.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
A risk assessment will be completed with the resident who successfully self medicates, which will detail the current controls in operation and if additional controls are required.
All staff reminded that each medication must have a pharmacy label to allow for safe administration of medicaion

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 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	31/10/2023
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	30/06/2024
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good	Substantially Compliant	Yellow	30/04/2024

	state of repair externally and internally.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	20/10/2023
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.	Substantially Compliant	Yellow	20/10/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	20/10/2023
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/04/2024
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for	Not Compliant	Orange	30/04/2024

	detecting, containing and extinguishing fires.			
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	31/10/2023
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	31/10/2023
Regulation 29(5)	The person in charge shall ensure that following a risk assessment and assessment of capacity, each resident is	Substantially Compliant	Yellow	31/10/2023

	encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	23/10/2023