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:	Arranmore
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Dublin 8
Type of inspection:	Unannounced
Date of inspection:	15 November 2021
Centre ID:	OSV-0003591
Fieldwork ID:	MON-0034737

About the designated centre

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

The designated centre is operated by St. John of God services and is situated on a campus based setting in South Dublin. It is a large one storey property that provides residential services for a maximum of 13 residents. There is one dining area, kitchen, 13 bedrooms, a staff office, a medication room, a family room and a TV lounge. There are two accessible bathrooms, two shower rooms and two toilets. There is a small grassy and paved area to the back of the building where residents, staff and family members can sit. There is also access to a swimming pool, day services, an oratory, gymnasium and multisensory room located on the campus. Residents are supported 24/7 by nursing staff, healthcare assistants and social care workers. Resident's have access to multidisciplinary supports in the organisation such as; social workers, physiotherapists, occupational therapists, speech and language and psychology, as required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	13

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 - 2015 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 15 November 2021	09:35hrs to 17:30hrs	Jennifer Deasy	Lead
Monday 15 November 2021	09:35hrs to 17:30hrs	Ciara McShane	Support

What residents told us and what inspectors observed

This inspection was an unannounced risk inspection. It was scheduled to inspect against the provider's compliance plan which was received subsequent to an inspection in the designated centre on 12 October 2021. High levels of non-compliance were identified on that inspection and a notice of proposed decision to cancel the registration of the designated centre under Section 51 of the Health Act 2007 (as amended) was issued to the provider. The provider submitted a compliance plan which detailed the measures they would take in order to come into compliance. The Chief Inspector also received several pieces of information regarding the quality and safety of care in Arranmore following the inspection. The current inspection was therefore scheduled in order to review the progress the provider was making in coming in to compliance and to follow up on the information received by the Chief Inspector.

The inspectors had the opportunity to meet with several residents and staff on the day of inspection. The inspectors used observations, interactions with residents, conversations with staff and a review of documentation to form judgments on the quality and safety of care in the centre. The inspectors wore face masks, engaged in good hand hygiene practices and maintained physical distancing at all times while in Arranmore.

Overall, the inspectors could see that the provider had completed a full audit of the designated centre, and had paid particular attention to the premises, infection prevention and control measures and fire precautions. It was clear that the provider was making attempts to come into compliance with the regulations and the inspectors acknowledged that the inspection took place in advance of the provider's estimated time frame for completion of all actions as set out on their compliance plan. For that reason, many actions remained in progress or outstanding on the day of inspection.

The inspectors saw that extensive premises works were in progress. These works were focused on one particular side of the building, with the other side scheduled to commence in the coming weeks. Several resident bedrooms were in the process of being repainted. Two bathrooms were also being refurbished. New flooring and skirting boards had been fitted in the dining room and one corridor. The living area had also been repainted. There was evidence that some measures had been taken to tidy the external part of the building. However, improvements were required in order to clean the back garden to a satisfactory standard and to make it inviting and accessible for residents. This will be discussed further in the quality and safety section of the report.

The inspectors observed that the provider had taken measures to enhance the staffing allocation to the designated centre. A chef had been employed in order to cater for the residents' complex dietary needs. Inspectors saw staff supporting residents in a kind and caring manner. The provider also informed the inspectors

through their compliance plan and verbally, on the day of inspection, that an activities co-ordinator had been employed for the centre. This activities co-ordinator was due to start at the end of November 2021 and would have responsibility for enhancing the activities available to those residents who did not attend day service. There were no in-house activities observed for residents on the day of inspection. However, residents were observed being supported with intimate care and with nutrition needs. Several residents were also observed to leave the centre on the day of inspection to go for a walk with staff. Staff spoken with, in relation to one resident with complex assessed needs, explained to inspectors how they follow the resident's lead and complete activities as requested by the resident. In the evening, residents were observed watching TV in the sitting room. The residents appeared comfortable and relaxed.

The inspectors spoke with several staff on the day of inspection. Staff reported that there was enhanced oversight of the designated centre, with management being more present and more easily available when required. Staff also reported that they had received training in several mandatory and additional areas since the last inspection. These trainings included in fire safety and person-centre care.

Residents spoken with were aware of the premises works ongoing in the centre. The provider had compiled an easy-read document explaining about the works and the increase in noise levels. The inspectors spoke with two residents who indicated that they had seen this document.

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

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided.

The inspectors found that the provider had recognised that enhancements were required to the oversight of the designated centre. The provider had committed through a comprehensive compliance plan to improving the governance and management arrangements of the designated centre. For example, in order to support the person in charge, a clinical nurse manager 2 (CNM2) had been recruited and recently commenced work in the centre. Additionally, the provider had committed through the compliance plan that the programme manager would be on site twice weekly and to meet with the staff at their staff meetings. Staff reported to the inspectors that they saw management in the centre on a more regular basis since the last inspection and that they felt more supported in their roles.

The provider had also completed a review of the training needs of staff. The inspectors reviewed the training records on the day of inspection and found that most staff were now up-to-date in mandatory training. Additionally, staff were undertaking to complete training in person centred planning with an external provider. Staff reported to the inspectors that they found this training informative and enhanced the care they provided to residents

The provider had made some changes to the staffing arrangements and had increased the whole time equivalent (WTE) staffing allocation for the designated centre from 34.5WTE to 38.5WTE. The provider had also increased the night-time staffing allocation to six WTEs to ensure safe evacuation of residents in the event of an emergency. However, a review of the rosters demonstrated that, on some nights, the staffing allocation was not in line with the revised staffing designation. A planned roster was available for the designated centre however no actual roster was maintained. This made it difficult to be definitive around which staff were on duty on any given day or night. A chef had been seconded from another service that the provider operated which further complimented the staffing allocations. However, further enhancements were required to the oversight of the food and nutrition, in particular to the planning of meals and purchasing food. This will be discussed further in the quality and safety section of the report.

While there were some improvements found in governance and management, information governance required improvement. Several documents as required by the inspectors were not readily available in the designated centre. The Schedule 5 policies, which the compliance plan set out had been reviewed and available in the centre since 12 October 2021, were found to belong to another designated centre and had been signed off on by staff working in that centre even though they were not specific to the needs of that centre. This was of concern as the provider had stated the action was complete but also staff were signing off on policies and procedures for the specifics of another centre. Therefore, it was unclear if staff were aware of the actual centre specific policies and procedures for the designated centre they were employed in. The statement of purpose for the designated centre was requested at 10.00am and was not received until after 15.00pm that afternoon. The provider's compliance plan stated that the statement of purpose had been reviewed on 11 November 2021 and was available in the designated centre, this was found to be inaccurate. Further improvements were required to the governance and management arrangements to ensure that actions were completed in line with the time frame as set out in the provider's compliance plan.

Regulation 15: Staffing

The provider had enhanced the staffing arrangements for the designated centre by increasing the whole time equivalent by four whole time equivalents. The revised whole time equivalent for the designated centre was set as 38.5. The provider had

also endeavoured to hire staff with qualifications which would further enhance the quality and safety of care for the residents. A chef, who had been seconded from another of the provider's centres, and a clinical nurse manager 2 (CNM2) had commenced employment in the centre. An activities coordinator was scheduled to start in the coming weeks.

There continued to be staffing vacancies in the centre on the day of inspection. The inspectors were informed that these vacancies were being recruited for.

A planned roster was available however an actual roster was not maintained. A review of the roster demonstrated that the staffing allocations were not always as set out in the statement of purpose, particularly the night-time staffing arrangements. However, the inspectors recognised that the night-time arrangements were enhanced since the last inspection even when deficits were noted on the roster.

The provider had further endeavoured to ensure that staffing arrangements were consistent for the residents by creating a panel of regular relief and agency staff.

Judgment: Substantially compliant

Regulation 16: Training and staff development

A review of the training records was completed by the inspectors. This review demonstrated that most staff were up-to-date in mandatory training. The provider had committed to having all staff up to date in mandatory training by 26 November 2021. Staff also had access to supplementary training in person centred planning and communication which they reported enhanced the care they provided to residents.

Staff reported that they were receiving supervision. The provider had committed to having completed supervision with all staff by 26 November 2021.

Judgment: Substantially compliant

Regulation 23: Governance and management

Overall, there was evidence to demonstrate that the provider had taken measures to enhance the oversight of the designated centre. The provider had completed several audits and had compiled a comprehensive quality enhancement plan for the centre. This plan set out time bound targets in order to address areas of non-compliance in Arranmore. A full-time person in charge was in place in the designated centre. The person in charge was supported in their role by a clinical nurse manager 2 (CNM2). Additionally, a programme manager, had committed to being present in the centre

on a twice weekly basis to assist in driving service improvements.

The provider had enhanced the staffing compliment by increasing the whole time equivalent and recruiting staff with additional skills required to meet the assessed needs of the residents.

However, further improvements were required to the oversight of the designated centre, and in particular to ensure that actions as set out in the quality enhancement plan and compliance plan were achieved to a satisfactory level and that the provider's audits were effective in identifying where gaps and deficits remained. For example, the compliance plan set out that the Schedule 5 policies and statement of purpose were available in the designated centre. However, these were not readily available on the day of inspection and took several hours to be provided to inspectors. Additionally, works which had been completed to clean the back garden had not been completed to a satisfactory standard, the back garden was not homely and it remained that attention was required. At the last inspection a considerable number of deficits were found in relation to infection prevention and control and whilst the provider had endeavoured to make some improvements there remained to be areas relating to infection prevention control that the provider had not outlined in their audits or rectified.

The provider's information governance systems also required a review to ensure that pertinent information relevant to the centre was available to staff as set out in the regulations such as the statement of purpose and the local policies and procedures.

It was recognised by the inspectors that the provider was at the start of a process of coming into compliance and had committed to addressing areas of non-compliance. There was evidence that the provider had taken steps already to begin to address issues.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose was not readily available in the designated centre. Due to the length of time it took for the statement of purpose to be furnished to the inspectors, it was not possible to review it on the day of inspection. The statement of purpose was submitted to the Chief Inspector and was reviewed subsequent to the inspection.

It was noted that the statement of purpose was in draft form with evidence of some amendments not completed. However, it was found to contain much of the information as required by Schedule 1 of the regulations. The statement of purpose reflected the ongoing changes to the centre in terms of governance and management and staffing arrangements. The statement of purpose noted that the floor plans required updating and that this will be completed subsequent to the

renovations.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

A folder of Schedule 5 policies was available in the designated centre however these policies were found to belong to another designated centre. The policies had been signed off by staff in the other centre. The programme manager informed inspectors that the Schedule 5 policies were being updated for Arranmore and therefore they had borrowed policies from another centre which had two copies for the interim period. The provider's compliance plan set out that the Schedule 5 policies had been reviewed and were available in the centre since 12 October 2021.

Judgment: Not compliant

Quality and safety

This section of the report details the quality of the service and how safe it was for the residents who lived in the designated centre. The inspectors observed that the provider was in the process of taking measures in order to come into compliance since the last inspection. The provider had submitted a comprehensive compliance plan and quality enhancement plan for the centre. These plans set out clear actions for the centre which were time bound and allocated to responsible individuals. There was evidence on the day of inspection that the provider had met some of their targets on these plans and were on track to achieve other targets. The provider had completed audits in the areas of premises, infection prevention and control and fire precautions. While it was clear that works were ongoing in premises and fire precautions, deficits continued to be observed in relation to infection prevention and control. An urgent action was issued to the provider on the day after the inspection and the provider was required to submit an urgent compliance plan response detailing how they had addressed these deficits.

Works on upgrading and maintaining the premises were taking place on the day of inspection. The inspectors observed that works were focusing on one side of the building in particular, with works on the other side to commence in the coming weeks as per the time-frame set out in the provider's compliance plan. The inspectors saw that the communal living areas had been repainted and were informed that new furniture and equipment had been ordered. The kitchen had received a deep clean and additional hygienic measures such as fly screens and signage had been installed. New flooring had been fitted to living areas and to one

corridor. Two bathrooms were in the process of being renovated.

Improvements were required to the oversight of maintenance work. The inspectors were told that the rear garden had been power washed and cleaned. Inspectors saw that cigarette butts and discarded PPE which were observed on the inspection in October 2021 had been removed. However inspectors noted that, while power washing had taken place, it had not been completed to a satisfactory standard with mud and debris left on the garden path. Inspectors observed that the wooden railings around the seating area were rotting. There were also broken flower pots and old household equipment such as a discarded mop and bin frame in the garden. These were removed by the provider on the day of inspection.

The inspectors were not assured that residents' personal items and belongings were respected. Inspectors saw that some residents' personal belongings had temporarily been moved to an outside patio area while their bedrooms were being painted. These items were left outside uncovered and as it was a damp day, were at risk of being damaged. Additionally, one resident had an open wardrobe which was uncovered during painting work. This left their clothing at risk of being damaged. The inspectors also saw, that some residents' belongings were not treated respectfully in their bedrooms. Inspectors saw a frame containing photo collages belonging to one resident on the ground behind their wardrobe. Another resident had many of their belongings stored on top of their wardrobe, some of which were stored in plastic bags. The same resident was using a medications box to store their shoes. In another bedroom, inspectors saw that the handles on one of the resident's drawers had broken which impeded access to their belongings. Cable ties had been attached in an attempt to open the drawers. This resident also had a kitchen style chair in their bedroom which had a torn seat pad. This was unsightly and presented an infection prevention and control risk.

Inspectors saw that much of the signage on resident wardrobes, as had been observed on the last inspection, had been removed. Some renovations, such as repairs to walls had commenced on the other side of the building however there were still considerable works to be done there. These works included painting all resident bedrooms, changing blinds and curtains and renovating bathrooms. The provider set out the time frame for full completion of these works to be by 28 February 2022 in their compliance plan.

In relation to residents' rights, the provider had set out measures in their compliance plan in order to consult with residents and involve them in the day to day running of the service. One resident continued to reside in this centre in spite of the provider being aware that it was an unsuitable environment. The provider set out a new time frame of summer 2022 to source more suitable accommodation for this resident. The provider had not taken adequate measures to secure residents' personal information. The inspectors observed that resident files continued to be stored on an open trolley in the dining room. Additionally, the inspectors found several archived files stored in an unlocked cupboard in the electrical supply store room.

While the provider had a local policy for safeguarding, and staff were trained, it was

found that the arrangements in place to record, document and follow through on safeguarding concerns in line with local and National policy required strengthening. The inspectors reviewed the safeguarding folder and found that where safeguarding incidents had been identified they were not all screened in line with policy nor were robust safeguarding plans completed for all safeguarding scenarios that required a plan. Where safeguarding plans were in place, they were not robust, appropriately risk rated and in some instances undated so it was therefore unclear if the plans were live or obsolete. A review of the centre's management of safeguarding incidents and adherence to both local and national policy was required.

There were ongoing issues with storage in the designated centre. Inspectors saw that residents required additional storage in their bedrooms and that there was lack of suitable storage for PPE. Additionally, inspectors also saw that staff continued to use an electrical supply room to store belongings. This restricted access to electrical cupboards in case of an emergency. The provider had outlined in their compliance plan response that this area had been cleared and was no longer in use for storage of staff belongings.

There were several infection prevention and control risks (IPC) identified on the inspection. These risks were considered so high that an urgent action was issued to the provider and the provider was required to come into compliance by 19 November 2021. The inspectors saw that some risks that had been identified on the last inspection as well as in the provider's own IPC audit had not been addressed. For example, personal protective equipment (PPE) required for use with suspect cases of COVID-19 continued to be stored on a radiator in a corridor. Inspectors also saw that several bathrooms were unhygienic and required a deep clean. One of these bathrooms continued to store several bins used for the disposal of intimate care products. These bins were stored beside the shower and, as well as reducing accessibility to the bathroom, presented an infection prevention and control risk to residents. A shower chair was also stored in this bathroom and obstructed access to the sink. There were no hand sanitising points available in this corridor. Staff were caring for one resident with suspected COVID-19 in a bedroom off this corridor. There was no way for staff to effectively clean and sanitise their hands prior to and immediately on exiting this bathroom.

One of the toilets in the same corridor was noted to have no hand soap, paper towel or toilet paper. The floor also felt sticky underfoot when walked on. On the day of inspection, there were two suspected cases of COVID-19 in the designated centre. The site specific management plan for COVID-19 set out that an outbreak management plan must be commenced immediately in the event of a suspected case of COVID-19. The provider had failed to activate their COVID-19 outbreak management plan.

The provider was in the process of taking measures to mitigate against the risk of fire. New fire doors had been fitted to the dining room. These had not, as of the day of inspection, been fitted with self-closing mechanisms. The fire doors were also observed to be wedged open. The wedges were pointed out to the CNM2 on the day of inspection and were removed. Staff had completed fire safety training. All resident personal evacuation plans had been updated. Additional staffing had been

allocated at night time to support an evacuation if required. A site specific emergency plan had been updated and was available on the day of inspection. The provider had also removed a shed and several waste bins which previously had been stored beside oxygen tanks and presented an additional fire risk.

Inspectors saw that a chef was employed in the designated centre who was responsible for the preparing and cooking of resident meals. The chef had not received a formal induction and was awaiting a meeting with clinicians regarding the residents' feeding, eating, drinking and swallowing plans (FEDS). In the interim, staff were modifying residents' meals once they had been cooked by the chef in order for them to be in line with the residents' assessed needs. The chef was also waiting on supply of specialist equipment such as a RoboCook to assist with meal preparation. Inspectors saw that the menu planning appeared to offer more nutritious meals than had been offered before. Meals cooked included quiche, chicken hotpot, leg of lamb and vegetables. Inspectors saw that meals which had been prepared were stored in clean sealed containers in the fridge. Where meals had been modified, foods had been blended separately so that they remained visually appealing.

Improvements were required to the oversight of food ordering and purchasing. Food was being purchased from multiple suppliers and this led to frequent menu changes depending on the availability of produce. Additionally, inspectors saw that carrots and sweet potatoes which were stored in a basket in the kitchen were mouldy as they had not been used on time. There was no fresh fruit available in the designated centre.

Supplements required to support residents' nutritional needs were also not stored in line with their prescribed storage recommendations. It was detailed on the supplement packaging that they should be stored out of direct light and in a room temperature environment. The supplements were stored in a brightly lit and warm room. The provider stated they were attempting to address the heating issues in the centre as several rooms remained very hot. This presented an additional IPC risk. Furthermore, staff stated that some residents dislike the heat and require fans to assist with sleeping at night time.

Regulation 12: Personal possessions

Residents did not have adequate space to store their clothes and personal property. Furthermore, some residents' possessions did not appear to have been maintained or treated with due care by the provider. Inspectors saw that one resident's photo collage was stored behind their wardrobe. Another resident had belongings stored in plastic bags on top of a wardrobe and shoes in a medication box. Where resident belongings had been moved out of their room during maintenance work, there was evidence that these were not stored in a respectful, appropriate and safe space.

Judgment: Not compliant

Regulation 13: General welfare and development

The provider had set out actions to be achieved through a comprehensive compliance plan and service improvement plan in order to support residents' general welfare and development. Many of these actions were time-bound to a later date than the inspection date and so had not been achieved on the day of inspection. The inspectors noted that the provider had recruited an activities co-ordinator who was due to start by the end of November and that reviews of residents' preferred activities and goals was in process. Several staff had already completed additional training in person centred planning and in communication. Staff reported that this was enhancing the quality of care provided to residents.

Judgment: Not compliant

Regulation 17: Premises

Works were ongoing to the premises at the time of inspection. Several resident rooms had been redecorated and new flooring had been laid in the communal living areas and one corridor. Two bathrooms were being refurbished. Further premises works were to be completed by February 2022. The back garden had been power washed but this work had not been completed to a satisfactory standard. The provider took measures to remove old household equipment from the back garden on the day of inspection.

Premises issues which required addressing and which had not been captured on the provider's compliance or service improvement plan included:

- insufficient storage for resident belongings
- broken and damaged furniture in resident bedrooms
- storage of staff belongings in a manner which restricted access to electrical supply boxes
- further cleaning of the back garden was required. Debris and mud was noted on the path which presented a falls risk to residents. The wooden railings were broken and the artificial grass was dirty and uninviting. A tin of purple paint had spilled on one windowsill and had not been painted over.
- bags of mortar were observed on the path
- a chair with moss growing out of the seat was being used to hold open an exit door. This chair had evidently been stored outside for some time
- bathrooms were visibly unclean and required a deep clean.

Judgment: Not compliant

Regulation 18: Food and nutrition

The provider had employed a trained chef to ensure that meals were cooked which were nutritious and were in line with residents' assessed needs. However, further oversight was required of the menu planning and purchasing of food for the designated centre. While meals offered appeared to offer enhanced nutritional value, there was evidence that meals were varied according to the availability of produce rather than as per the menu and residents' preferences. Inspectors also found that some fresh vegetables had not been used in an adequate time frame and had become mouldy. There was no evidence of fresh fruit in the designated centre.

Inspectors saw that meals which were modified were blended in a way to retain their appeal of colour. Inspectors also saw staff supporting residents with their food and nutrition in a caring manner and as per residents' assessed needs.

Judgment: Substantially compliant

Regulation 27: Protection against infection

While the provider had completed an infection prevention and control (IPC) audit and had identified areas for improvement, the inspectors were not assured on the day of inspection that the provider had adequate mechanisms in place in order to reduce the risk of residents contracting a health care associated infection.

Several IPC risks were identified on the day of inspection. An urgent action was issued and the provider was required to come into compliance by 19 November 2021. These risks included:

- bathrooms required a deep clean. Bathrooms were noted to smell damp and were dirty with mildew in the grout and stains in the shower tray
- some bathrooms required additional equipment such as toilet seats
- bathrooms were storing high numbers of bins for intimate care waste. This restricted access to showers and presented an IPC risk to residents. Shower equipment was stored blocking access to a sink on one bathroom
- a ski-sled was stored in a bathroom wedged between waste bins
- there were no hand sanitising stations in one corridor.
- the provider had not completed a COVID-19 outbreak management plan in spite of having two suspected cases of COVID-19 at the time of inspection
- there was insufficient storage of PPE required to support residents with suspected COVID-19
- there was an absence of toilet paper, soap and hand towels in one toilet
- the utility room was dirty with broken furniture stored in it

- the building was excessively hot

The provider submitted an urgent compliance plan on 19 November 2021 which detailed the measures they had taken to address these actions.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider was in the process of implementing measures to mitigate against the risk of fire. All staff had completed fire safety training. The provider had fitted several new fire doors within the centre. Self-closing mechanisms were expected to be fitted to these in the coming weeks. Two fire doors were observed wedged open. This risk was pointed out to the CNM2 on the day and was addressed. The night-time staffing allocation had been increased in order to ensure that all residents could be safely evacuated in the event of fire. However a review of the rosters demonstrated that night-time staffing arrangements were not always at the allocated level. Inspectors also saw that a ski sheet necessary for the evacuation of some residents was stored in a bathroom and would not have been easily accessed in the event of a fire.

Judgment: Substantially compliant

Regulation 8: Protection

There was a safeguarding folder maintained in the designated centre which was shared with inspectors. From a review of the folder it was evident that some safeguarding incidents were being recorded and screened in line with local and National policy. However, it was found that all steps as required, and as outlined in the National policy, were not being followed. For example, for a number of incidents which were screened only part of the form was complete and where reasonable grounds had also been established there was an absence of a follow through and a clear safeguarding plan was not put in place. This demonstrated a lack of understanding regarding the requirements as outlined in national policy but also lack of importance placed on the need for robust safeguarding plans to protect residents from all forms of abuse.

Some of the safeguarding plans reviewed did not have a date on them, nor where they highlighted as being reviewed, it was therefore unclear if they were active safeguarding plans or obsolete.

It was also found that there were some delays in staff reporting safeguarding concerns and it was not always clear if safeguarding concerns had been refereed to

the national safeguarding team as required. Additionally where a Trust in Care investigation had been completed the outcome of these were not always recorded.

Judgment: Not compliant

Regulation 9: Residents' rights

The provider had set out several actions in their compliance plan in order to ensure that residents' rights were respected. It was recognised by the inspector that the provider was at the beginning of this process on the day of inspection, and had not, at that point, achieved their targets. The provider had committed to enhancing the arrangements in place to support resident rights and had set targets for the coming months.

Staff were in the process of completing additional training in person centred planning and communication at the time of inspection. However the inspectors observed that residents' rights to privacy in relation to their personal information was not always respected. Resident files continued to be stored on an open trolley in the dining room. This had been identified as an area of non-compliance on the inspection in October 2021.

One resident continued to reside in this centre in spite of the provider being aware that it was an unsuitable environment for several years. The provider set out a new time frame of summer 2022 to source more suitable accommodation for this resident.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Arranmore OSV-0003591

Inspection ID: MON-0034737

Date of inspection: 15/11/2021

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Person in Charge (PIC) has ensured; • A review of this roster has been undertaken by the PM on the 02 November 2021 to address the staffing shortfalls in the Centre. • The roster has been amended to include to reflect full staffing complement for the DC including two additional staff on night duty and an Activities Instructor. • The Registered Provider is now assured the roster has an appropriate skill mix of health and social care staff to safely support and meet the assessed needs of the residents. • There is a planned and actual roster available in the Centre which confirms the staffing levels and grade for each shift. These rosters are communicated to all staff of the Centre via email. Hard copies are also available in the staff office. This roster is monitored; any issues that arise are addressed by the PIC. • Designated 'Shift Leaders' are present on each shift and roles and responsibilities of same have been outlined to all staff by the PIC and the PM. • An Activity Instructor commenced in the centre on 29 November 2021 to lead community inclusion and meaningful activities for all residents. • A professional chef has commenced at the centre from 01 November 2021. • A recruitment campaign has commenced to recruit a Clinical Nurse Manager 1 and to source competent staff for other existing vacancies in the Centre. On an interim basis, relief and consistent agency staff are deployed. • On an interim basis, agency staff have been identified, inducted and rostered to ensure adequate and appropriate levels of staffing within the Centre.	
Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The PIC will ensure the following;
• A review of the training records for all staff was completed on 26 October 2021.
• All staff working in the Centre have completed mandatory training (IPC, Safeguarding vulnerable people, Dysphagia, Fire Safety, Manual Handling).
• Staff have attended a Person Centred Approach Action Workshop. This is ongoing and is improving the delivery of services provided to residents
• The Senior Speech and Language Therapists has commenced delivering Triple C Communication training for staff from the 19 November and will continue until all staff have received this training.
• A training schedule and audit is maintained by the HR department and updated weekly by the PIC.
• Weekday practice development sessions have commenced for all staff on duty from 09 November 2021 by the PIC.
• Formal staff supervision commenced on the 27 October 2021. 26 staff have completed supervision. A schedule has been developed for the remainder.
• A system is in place to induct all new staff including relief and agency. This will be provided by the PIC and/or the most senior staff member on duty. An induction booklet is available to support this process.
• The chef has received a formal induction into all residents in the centre. The chef has met with the PIC, CNM2, SLT and Dietician regarding residents nutritional needs.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The RP has ensured the following;
• A review of the governance and management structure for the Centre has been undertaken.
• A Clinical Nurse Manager 2(CNM2) commenced on the 15 November 2021.
• A recruitment campaign has commenced to recruit a CNM 1.
• The registered provider (has appointed a full time supernumerary Person in Charge (PIC) who is the Residential Coordinator to the Centre with effect from 8 November 2021.
• The PIC is solely responsible for this Centre. The person has the required skills, knowledge, experience and qualifications necessary for the role.
• There is a planned and actual roster available in the Centre which confirms the staffing levels and grade for each shift. These rosters are communicated to all staff of the Centre via email. Hard copies are also available in the staff office. This roster is monitored; any issues that arise are addressed by the PIC.
• A review of this roster has been undertaken by the PM on the 02 November 2021 to address the staffing shortfalls in the Centre. The roster has been amended to include

additional staffing to include two additional staff on night duty, one activities coordinator and 1 professional chef. The Registered Provider is now assured the roster has an appropriate skill mix of health and social care staff to safely support and meet the assessed needs of the residents.
• There is a procedure in place for arranging cover for all staff absences. This is discussed at the daily handover.
• A Safety Pause takes place daily in the Centre, facilitated by the PIC or senior staff member on duty since 8 November 2021.
• The PM links in daily with the managers and shift leaders in the Centre to receive an update on resident, staffing levels, incidents, any safeguarding concerns and issues.
• The PM and PIC complete weekly workaround's of the Centre to identify areas that require attention.
• The PIC and Operations Manager oversee all works in Centre to ensure they are completed as required.
• Formal staff supervision commenced on the 27 October 2021. 26 staff have completed supervision to date. A schedule has been developed for the remainder.
• A schedule of monitoring and compliance meetings have been scheduled between the PM and the PIC, taking place fortnightly for the first three months and monthly for six months post the three month timeline.
• The PIC, CNM2 and PM will meet formally monthly to discuss concerns and issue and the PM will raise with the Regional Director at the PM monthly Director's meeting.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The RP has ensured that;
• Statement of purpose has been reviewed and updated on 28 November 21 by the PIC/PM to contain the information set out in Schedule 1.
• Amended floor plans following renovations have been submitted to the inspector on 30 November 2021.
• A copy of the Statement of purpose is available in the centre.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The Registered Provider (RP) has ensured the following;

• Local and Organisational policies are available to staff in the Centre.
• Weekday practice development sessions occur with staff within the Centre, from 09 November 21 and they include discussion on the implementation of the Schedule 5 policies and procedures.
• Policies are a standing item at each staff meeting and formal supervision meeting.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
The PIC has ensured the following;
• A review of the laundry system took place and a new system in place since 19 November 21.
• Additional storage for the residents in their bedrooms has been provided since 26 November 21.
• All labels are removed and names off doors and wardrobes.
• An inventory of belongings is in place for all residents since 30 November. This will be reviewed monthly by the keyworker and the resident. Any items that are worn or in disrepair will be discussed with the resident.
• Wardrobe doors have been ordered for all resident bedrooms, these will be installed in January 2022 due to delay in materials.

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 RP has ensured that;
• To support all residents' meaningful day, their schedules are currently being reviewed and updated to reflect their preferred activities and will and preference.
• All staff have received Person Centred training.
• Keyworkers are working directly with residents and their representatives to support them to identify their preferred activities and personal goals.
• An Activity Instructor has been identified to develop and drive the meaningful day experience based on the will and preference with the residents.
• The Activity Instructor has commenced on 29 November 2021

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The RP has ensured the following:
• An environmental audit and an infection control audit were completed on 15 October 2021
• All practices relating to labelling of residents furnishings has been discontinued from 13 October 2021.
• Painting and decorating of the communal areas in the Centre has been completed. Residents were consulted about their preferences for redecoration of their bedrooms. Completed 26 November 2021
• New flooring was installed in the communal areas and resident bedrooms. Damaged walls have been repaired with the exception of one resident's bedroom. A plan is being developed with the CNS (Behaviour) for that resident to repaird and decorate that resident's bedroom.
• One bathroom has been refurbished to a wet room to allow the bathroom to become more accessible to residents completed 26.11.21.
• A further bathroom was converted into a wet room completed 10 December 2021.
• In addition, a further two bathrooms will be refurbished by 28 February 2022.
• A review of the heating system took place on 19 November 2021. The heating has been reduced in the centre via a timer system. New variable pumps and thermostatic valves will be in place in early 2022 once relevant pumps become available from contractors.
• New furniture for communal areas has been purchased and is in place since 26 November 2021.
• Externally, the premises have been power washed on 3 December 2021.
• An internal deep clean of the full premises was completed on 3 December 2021
• A review of cleaning schedules took place and improved cleaning checklists are in place and being monitored to ensure a high standard of cleanliness.
• Velux window will be in place by 20 December in the medication room to allow for better temperature and air control.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
The PIC has ensured the following;
• Following a review of the mealtime experience by the PIC and PM on 27 October 2021, staff breaks are managed appropriately to ensure there are adequate and appropriate staffing levels at mealtimes.
• The Chef has responsibility in consultation with keyworkers and residents for meal

planning, choice, preparation and cooking of meals in line with the residents' specific modified diets and the organisations food, nutrition and hydration policy.
• The Chef checks all fresh fruit and vegetables during their shift to ensure they are of edible quality, reports any concerns to the PIC.
• The Speech and Language Therapist (SALT) has completed a review of all residents' dysphagia plans. 04 November 2021. The SALT has completed refresher dysphagia training with all staff in the Centre.
• A mealtime experience audit was conducted by General Services Co-coordinator. 23 November 2021.
• There is a mealtime experience document for the centre.
• A referral for all residents was made to a private dietician on 27 October 2021 by PM for assessment purposes.
• The private Dietician is commencing assessments with residents with effect 10 December 2021.
• Residents meetings are being held weekly with effect from 12 November 2021.
• In conjunction with SALT consultation and following Triple C training for staff the format of these meetings will be under review and will be redesigned to a more meaningful format/forum for the residents of the Centre. The Activities coordinator and SALT team are developing a more meaningful template at present. Weekly resident meetings taking place each Friday evening in the interim

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The Registered provider has ensured the following;
• Deep clean of bathrooms completed 17.11.21
• Full clean of the building by housekeeping staff and validated by the PIC with comprehensive site specific cleaning checklist completed 17.11.21
• New toilet seat and lid in place, completed 17.11.21
• Intimate Care bins collection by contractor increased to daily Monday to Friday with effect from 19.11.21
• Ski Sled removed from bathroom and positioned appropriately in corridor outside resident's bedroom completed 17.11.21
• Review of the number of additional hand sanitizers required completed 17.11.21 with an additional 13 hand sanitizers in place with effect from 19.11.21
• Review of Covid Outbreak Management Plan completed 17.11.21 by the Programme Manager, actions identified are outlined on this compliance plan.
• Appropriate PPE trolley purchased 17.11.21 and in place for the correct storage of PPE with regards to a suspected or positive case within designated centre.
• Shift Leaders checklist and housekeeping checklist amended to ensure that appropriate materials for each bathroom is in place at all times within the designated centre. Completed 17.11.21.

• Deep clean of utility (laundry) room completed 17.11.21. Any unnecessary or broken furniture was removed. Completed 17.11.21
• As per pre-arranged agreement with heating contractors, heating contractors on site to review the heating system in the designated centre on 17.11.21. Recommendations will be actioned in early 2022 due to delayed availability of variable pumps required.
• As an interim measure, the heating will be managed using a timer system to regulate the temperature with effect from 17.10.21 which has successfully reduced the heat within the DC.
Velux window being installed in medication room to be completed by 20 December to regulate temperature.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Centre risk register was reviewed by the Clinical Safety Manager and the PIC on the 12 November 2021 and respective risk assessments have been updated.
• All Personal Emergency Evacuation Plans have been reviewed to reflect changes in their evacuation procedure.
• All staff have completed online fire safety training.
• Refresher fire extinguisher training by an external fire expert has been completed by all staff since 30 November 2021.
• Fire doors in the Centre have been fitted with magnetic fire door closers that have been connected to the fire system. 18 November 2021.
• All files and personal belongings have been removed from the electrical supply cupboard and stored in a different location. Files have been archived.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The RP will ensure the following;
• A review of all safeguarding incidents in the centre has been completed by the PIC/PM on 20 November 2021
• All staff have received refresher training in Safeguarding, in addition staff have attended workshops on Safeguarding facilitated by the Social Work Team Leader.
• All bathrooms are checked regularly throughout each shift to ensure there is adequate supply of hand paper towels, hand soap and toilet paper.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The RP has ensured that;
• All labels have been removed from the resident's bedrooms.
• In relation to the Resident that requires a low arousal environment, alternative accommodation has been identified and funding and extensive works are required to bring this location in line with regulation. The timeframe has been adjusted to the 29 July 2022.
• This Resident's positive behaviour support plan was reviewed by the CNS for Behaviour and updated to ensure the Resident's dignity and privacy is protected.
• Staff have received training in Person Centredness.
• In conjunction with Speech and Language Therapists consultation and following Triple C training for staff the format of these meetings will be under review and will be redesigned to a more meaningful format/forum for the residents of the Centre. Weekly resident meetings are taking place each Friday evening in the interim.
• An alternative location has been identified for residents to use at evenings and weekends for preferred individual activities since 15 November 2021.

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 12(3)(d)	The person in charge shall ensure that each resident has adequate space to store and maintain his or her clothes and personal property and possessions.	Not Compliant	Red	22/02/2022
Regulation 13(1)	The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.	Not Compliant	Red	22/02/2022
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to	Not Compliant	Red	22/02/2022

	participate in activities in accordance with their interests, capacities and developmental needs.			
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.	Substantially Compliant	Yellow	07/01/2022
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.	Substantially Compliant	Yellow	07/01/2022
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Not Compliant	Orange	07/01/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate	Substantially Compliant	Yellow	30/01/2022

	training, including refresher training, as part of a continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/12/2021
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Red	22/02/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Red	22/02/2022
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Red	22/02/2022
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff	Not Compliant	Red	22/02/2022

	shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Red	22/02/2022
Regulation 18(2)(b)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are wholesome and nutritious.	Substantially Compliant	Yellow	30/11/2021
Regulation 18(2)(c)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which offers choice at mealtimes.	Substantially Compliant	Yellow	30/11/2021
Regulation 18(2)(d)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which	Substantially Compliant	Yellow	30/11/2021

	are consistent with each resident's individual dietary needs and preferences.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	07/02/2022
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Substantially Compliant	Yellow	07/02/2022
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	Red	22/02/2022
Regulation 23(3)(a)	The registered provider shall ensure that	Substantially Compliant	Yellow	07/02/2022

	effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.			
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Substantially Compliant	Yellow	07/02/2022
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Red	19/11/2021

Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	31/12/2021
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	31/12/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/12/2021
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	30/11/2021
Regulation 04(1)	The registered provider shall prepare in writing and adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	30/11/2021
Regulation 04(2)	The registered provider shall make the written policies and procedures referred to in paragraph (1) available to staff.	Substantially Compliant	Yellow	30/11/2021
Regulation 08(2)	The registered provider shall protect residents	Not Compliant	Red	07/01/2022

	from all forms of abuse.			
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Red	07/01/2022
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Red	22/02/2022