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:	Ashington Group - Community Residential Service
Name of provider:	Avista CLG
Address of centre:	Dublin 7
Type of inspection:	Unannounced
Date of inspection:	07 July 2023
Centre ID:	OSV-0003979
Fieldwork ID:	MON-0037129

About the designated centre

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

The Ashington Group consists of three community-based homes and is part of a community residential service operated by Avista CLG (formerly known as Daughters of Charity Disability Support Services CLG) that provides a high level of support and care to up to nine people with intellectual disabilities. The community houses are situated in quiet residential areas. All residents living in Ashington Group have single occupancy bedrooms. All houses have communal bathrooms, kitchen, dining and sitting room areas and rear facing gardens. The three houses are long stay residential homes which are open 24 hours a day, seven days a week. They are staffed by a person in charge, staff nurses, social care workers and health care assistants. Staff support residents to attend day services or individual activities daily.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Friday 7 July 2023	10:40hrs to 17:40hrs	Erin Clarke	Lead

What residents told us and what inspectors observed

This designated centre consists of three community houses. Two houses are located in a housing estate next door to each other. The third house is a detached house a short drive away from the first two houses. One person in charge manages the centre with a separate staff team for each house.

The purpose of this inspection was to assess the centre's ongoing compliance with the regulations. The centre's last inspection was in December 2021. There had been significant improvements to the quality of care and support provided to residents living in the centre, which, overall, resulted in positive outcomes for residents. The provider had made improvements to the centre since the last inspection and, in particular, in relation to the premises. During the previous inspection in December 2021, one resident was using a living room as a bedroom for a temporary period due to not being able to access their bedroom located upstairs. The provider had addressed the support needs required by the resident by transitioning the resident to an appropriate home that better met their needs. Subsequently, the provider submitted an application to vary the conditions of registration by reducing the capacity of the centre from ten to nine residents.

Over the course of the inspection, the inspector met with four residents living across two houses, several staff members, the incoming person in charge, who was the social care leader, and a senior manager who was the acting person in charge. The inspector found improvements had been made since the previous inspection. This inspection identified that further enhancements were required in the areas of fire safety, behavioural support, maintenance and resources in the centre.

On arrival to the two semi-detached houses, the environment was busy, with all residents engaging in their morning routines. As detailed in the centre's annual review, these two properties had a large communal conservatory at the back of both houses. The back door from each house led directly into the conservatory by which the staff and residents access the other house through this area. There are also interconnecting doors that are only meant to be used in the event of an emergency. One of these doors is located downstairs through the kitchen, while the other is located upstairs through two bedrooms. During the course of the inspection, the inspector saw that the doors that connect the two buildings through the bedrooms were both closed and unused on their respective sides. The purpose of keeping the downstairs doors closed was to provide a quieter environment and separate living spaces for the residents of both houses. The inspector observed this door wedged upon along with the door entering the conservatory. This practice was not in line with the centre's statement of purpose, and it also invalidated the fire containment measures between the two houses as this door was a fire door.

On other occasions, during the inspection, the inspector observed staff exiting and entering through the two kitchens. From speaking with staff, it appeared this was due to the supervision requirements of residents and the requirement of some staff

to administer medicines to residents across both houses. It was also not clear the purpose of having the interconnecting doors for emergency purposes while reviewing the fire evacuation routes of the houses.

Some residents living in this centre attended day services, while others were supported by staff in the centre with their social and leisure activities. The inspector met all of the residents during the inspection. Most residents appeared relaxed in their homes, and some chose to speak with the inspector. One resident was anxious to leave the centre on their favourite activity. While the houses had their one dedicated vehicle, only one staff on shift was able to drive the car, so the resident had to wait until the car was available. Staff were seen to reassure the resident that they would be going on their activity. The inspector met with the resident again on their return from being out, and they appeared once again wanting to go out again and leave the centre. The inspector reviewed documentation relating to the resident's will and preferences, and it was clear that the resident liked to engage in certain activities in the community. The resident had expressed that they did not want to return to formalised day services programmes and, therefore received individualised supports from their home. From reviewing the staffing arrangements and, in particular, the number of staff that could drive the centre's vehicle, the inspector was not assured that the resident's preferred level of engagement in the community could always be accommodated.

It was clear however, that residents were to the forefront of care, and each resident met with their keyworker on a monthly basis to discuss any activities which they would like to engage in or any interest in personal development they may have. The inspector met with one resident who was recovering after an accident. They told the inspector they had received good support from staff and the organisation's physiotherapist in managing their injury. This resident showed the inspector examples of goals they were working on and how they were involved in assuring the rights of residents were upheld. The resident was a member of the organisation's advocacy group and was the 'Champion of Rights' within the centre. The resident had a DVD made of them singing their favourite songs in a recording studio as part of an identified goal with their keyworker.

Printed photographic booklets of the highlights of residents' lives in 2022 were available in the centre. Residents showed these to the inspector, and it was evident that residents had opportunities to go on holidays, attend concerts, be with their friends and enjoyed spending time with staff. A movie was also created to capture these memories for residents to look back on.

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

Capacity and capability

The purpose of this inspection was to assess the provider's compliance with the regulations. The inspector observed evidence that the registered provider was making progress with bringing the service into regulatory compliance. However, improvements were required in relation to staffing and the completion of actions identified through the local governance systems.

The inspector found that the provider had satisfactory arrangements in place to assure itself that, overall, safe and good quality service was being provided to the residents who lived in the designated centre. The service was led by a capable social care leader, who was due to become the centre's new person in charge. They reported to a clinical nurse manager who was covering the position of the person in charge. Both individuals were knowledgeable about the support needs of the residents, responsive to the regulator and were available to facilitate the inspection.

As part of an organisational governance review, the provider applied to vary the centre's footprint in June 2023, removing one house from the designated centre. This would reduce the capacity of the person in charge who currently splits their time between three houses. At the time of the inspection, the application was being progressed.

The inspector found that the provider had addressed inconsistent governance arrangements that had been evident in the centre in 2022. The person's in charge position had been vacant since September 2022, resulting in improvements not being sustained or compliance with the regulations as identified in provider audits of the centre. As an interim measure, the provider redeployed the person participating in management (PPIM), a clinical nurse manager who was based in the provider's central office, to the centre for six weeks. During this period, staff received supervision and additional oversight was given to operational matters in the centre.

The provider had completed an annual review and twice per year unannounced visits to review the quality and safety of care provided in the centre, as required by the regulations. The annual review was completed in February 2023 for the year 2022 and involved consultation with residents and their representatives, as required by the regulations. While the report identified a number of areas for improvement, it did not assign actions to a named individual and provide a time frame for completion. Therefore, at the time of the inspection, it was unclear which actions had been completed as action status updates had not been provided.

On the previous inspection, it was found that improvements were required to the staffing levels in the house as there was a considerable reliance on agency and relief staff to support the permanent staff team due to a number of vacancies. The inspector found significant improvement in the reduction of vacancies in the centre and, therefore, the need for unfamiliar staff had decreased. Staff spoken with informed the inspector of the improvements over the previous year, including having a full-time person in charge and a lesser reliance on external staff to fulfil the staff roster.

Registration Regulation 8 (1)

The provider had submitted a full and complete application to vary the conditions of the centre's registration.

Judgment: Compliant

Regulation 14: Persons in charge

On a review of documentation in advance of the inspection, the inspector found that the current person in charge had the appropriate qualifications and skills and sufficient practice and management experience to oversee the residential service to meet its stated purpose, aims and objectives. The person in charge held a larger governance remit within the service and previously held the role of being the line manager for the person in charge. During the inspection, it was found that a new social care leader had commenced in February 2023 and was awaiting the completion of a management course in July 2023 in order to be appointed the person in charge role.

Judgment: Compliant

Regulation 15: Staffing

The three houses in this centre had a whole-time equivalence of 18 staff, including nurses, social care workers and healthcare assistants. There was one vacancy in the centre at the time of the inspection, and the post was under recruitment. Two staff members were on long-term statutory leave. On review of the roster, the inspector saw that where there were gaps, these were covered by core staff working additional hours, relief and agency staff. The provider was endeavouring to provide continuity of care by employing the same cohort of relief and agency staff when possible.

Throughout the day, staff who spoke with the inspector demonstrated good understanding of the residents' needs and were knowledgeable of policies and procedures which related to the general welfare and protection of residents living in this centre.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had identified on their annual report and other provider audits, that improvements were needed to ensure all staff were provided with appropriate training and refresher training. These were being completed at the time of the inspection.

The inspector was informed that due to findings from other inspections within the organisation, additional training was taking place with relief and agency staff to ensure all staff could safely support residents' medical needs with rescue medicines that required specific training.

Improvements were also being made to ensure the training records of relief staff were maintained and retrievable in line with the requirements of the regulations. However, the training records for agency staff were not included in this review, resulting in a gap of training records for review by the inspector. This is actioned under Regulation 21: Records.

One-to-one supervision meetings between staff and management were taking place regularly and there was a schedule in place which was in line with the organisation's policy.

Judgment: Compliant

Regulation 21: Records

The registered provider was enquired to ensure that information and documentation in relation to staff specified in Schedule 2; were maintained and made available for inspectors to view. The provider did not routinely seek Schedule 2 files for agency staff from the agency's employment provider.

Records relating to one resident who had recently transitioned out of the centre were also not available in the centre for the inspector's review as required by the regulations.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had recognised that during a period of absence, the local monitoring systems in place had not been kept up-to-date and had devised interim measures to

ensure these were effective in ensuring positive outcomes for residents.

The provider sought to reduce the number of houses that constitute this designated centre from three to two and therefore decreasing the person in charge remit. This would allow them to base between the two semi-detached houses and provide increased oversight of the delivery of services. The third house would be joined with a house of similar support needs to form a new designated centre with its own dedicated person in charge.

While the number of staff employed in the centre appeared to meet the needs of residents, due to some transitions and changing needs, the staffing arrangements were required to be kept under review. Also, the inspector found that across two houses where ten staff worked, only one staff was able to drive the house vehicle. The inspector found on the day of inspection; this caused some delays to residents going to their preferred activities. It was also not an available option for residents when this staff member was not rostered to work.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

Overall, the statement of purpose accurately described the service provided in the designated centre and was reviewed at regular intervals. Some amendments were required to the document to ensure the correct members of management were identified as per the registration certificate of the centre. Also, on review of the additional charges that residents could incur, these related to an older AVISTA policy and were no longer relevant and, therefore, required updating.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The inspector found that the residents were aware of the complaints process, and it was available in an easy-to-read format displayed for residents' review. Complaints were discussed weekly at the centre's residents' meetings. There was access and information available to residents in relation to advocacy services.

The complaint's procedure was monitored for effectiveness, including outcomes for residents to ensure that residents received a quality, safe and effective service. The annual review in February 2023 identified improvements that could be made to the complaints process. For instance, three complaints had been logged in 2022 relating to residents' access to day service with no resolution at the time of the review. Another complaint made in January 2023 also had not been recorded in line with the

provider's policy. The inspector found that the provider had responded to complaints made by residents or those made on their behalf to bring a solution to restricted day service access. While there was an ongoing review of residents' current and changing needs, the provider had allocated specific day-service staff to the centre two days a week to support resident activities.

Judgment: Compliant

Quality and safety

The well-being and welfare of residents were maintained to a good standard of care and support. On speaking with the person in charge, social care leader and staff, the inspector found that they were aware of the residents' needs and knowledgeable in the person-centred care practices required to meet those needs. Actions from the last inspection of the centre had been completed, many of which had resulted in positive outcomes for residents. However, on the day of the inspection, the inspector found that some improvements were needed, particularly regarding fire safety measures, outstanding premises works and positive behavioural support for residents.

It had been identified by the annual review process in February 2023 that improvements were required to some of the fire safety features in the designated centre. Some actions had been completed since the review. For example, while each resident had a personal emergency evacuation plan, these needed review to ensure the detailed support required by each resident was clear. The person in charge had prepared evacuation plans to be followed in the event of the fire alarm activating, and each resident had their own evacuation plan, which outlined the supports they may require in evacuating. However, for other actions, these remained outstanding for a long period of time. It had been identified during the previous two annual reviews that fire extinguishers required relocation and improved signage to ensure they were visible and accessible. The inspector observed that these recommendations had not been completed during the walkaround of the centre, and it was unknown as to when these would be actioned.

The residents were protected by practices that promoted their safety. Staff received the necessary training in order to ensure the safety of the residents. There were safeguards in place to ensure that staff who provided personal intimate care to residents did so in accordance with each resident's individual plan and with respect for their bodily integrity and dignity. The provider had systems in place to ensure residents were safeguarded from financial abuse. The person in charge carried out a monthly audit of the residents' finances to ensure each resident's money was maintained appropriately.

Residents' healthcare needs were met through timely access to healthcare professionals and the ongoing monitoring of their healthcare needs. Residents had

an annual review of their healthcare needs with their general practitioner (GP) and had access to a range of professionals such as physiotherapy, speech and language therapy and nursing staff. Regular reviews with allied healthcare professionals had been facilitated, and healthcare plans were updated based on the recommendations made by professionals. Systems were in place to ensure that where behavioural support practices were being used that they were clearly documented and reviewed by the appropriate professionals. However it was identified by the social care leader that one plan was overdue a review and they had escalated this to the relevant multi-disciplinary team member.

Regulation 17: Premises

The social care leader accompanied the inspector on a thorough walkaround of the centre. Many parts of the centre had been recently renovated and redecorated. For example, new windows and a roof had been installed in the conservatory, making it a more pleasant place for residents. Overall, the centre was found to be clean, bright, homely, well-furnished, and appropriate to the assessed needs and number of residents. Outstanding works were identified in the upgrading of kitchens, laundry facilities and storage. These actions, while identified in many audits of the centre, did not have a time-bound plan for completion.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Improvements were needed to ensure that outstanding actions relating to fire safety works were completed and in a timely manner. It had long been identified that fire extinguishers required review and relocating to ensure ease of use in the event of a fire. Also, the practice of holding fire doors open, overriding the close-shut mechanism, was evident with the use of door wedges.

Judgment: Not compliant

Regulation 6: Health care

Recommended healthcare interventions were found to be implemented, such as daily physiotherapy exercises. Residents' healthcare needs were monitored on an ongoing basis. For example, scheduled blood tests were completed, and residents' blood pressure were monitored as recommended.

Where residents did not want to engage in healthcare interventions or required

additional information in order to make informed decisions regarding their care, the inspector found the staff and the person in charge were cognisant of residents' rights and supported residents to make choices.

Judgment: Compliant

Regulation 7: Positive behavioural support

Overall, the provider and person in charge promoted a positive approach in responding to behaviours of concern. There were systems in place to ensure that where behavioural support practices were being used that they were clearly documented, and residents had support from the appropriate professionals on a regular basis. However, not all residents' positive behavioural support plans had received a timely review and update. The incoming person in charge had escalated to the provider that one positive behavioural plan had not been reviewed since 2021. At the time of the inspection, there was no update as to when this would occur.

There was one restrictive practice notified to the Chief Inspector in 2023. This was the use of a bed sensor to alert staff if a resident needed support during the night. However, due to the transition of the resident to another designated centre, this restrictive practice had recently ceased.

When applied, restrictive practices were clearly documented and were subject to review by the appropriate professionals. The restrictive practices were supported by appropriate risk assessments, which were reviewed on a regular basis.

Judgment: Substantially compliant

Regulation 8: Protection

Residents were provided with safeguarding plans which provided adequate guidance for staff to support the reduction of safeguarding incidents. Safeguarding plans were regularly reviewed and updated, and the person in charge and staff were conscious that a stable staff team were key to reducing negative interactions between residents. There had been a decrease in the number of safeguarding incidents between 2022 and 2023. In addition, residents were regularly supported by positive behavioural supports and plans.

Judgment: Compliant

Regulation 9: Residents' rights

It was clear that residents rights were actively promoted in this centre.

There was evidence that the incoming person in charge had identified any potential rights restrictions in the centre, and the rationale of such restrictions were appropriately explored. This resulted in a review of and elimination of some practices. For example, some items taken out of bathrooms were reintroduced. Furthermore, where portion-controlled diets were used, these were evaluated for consistency with an identified health action plan or a behavioural support plan.

Key working sessions were completed regularly. These sessions were carried out using a person-centred approach where the input and decision-making of residents was prioritised as much as possible.

Information on rights were clearly displayed and the residents' forum was used as a platform to further raise awareness of their rights. In addition, the centre had an open and transparent culture and residents reported that they could could to any staff member if they were dissatisfied with any aspect of the service.

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	
Registration Regulation 8 (1)	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Ashington Group - Community Residential Service OSV-0003979

Inspection ID: MON-0037129

Date of inspection: 07/07/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • The PIC will ensure that records relating to any resident who has transferred out of the center are maintained and available within the center. • The register provider has an agreement with agency staff providers that requires that they ensure that their staff's documentation is up to date and compliant with legal requirements.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The register provider has an agreement with a local taxi company to facilitate preferred activities for residents, when no driving staff are rostered on duty.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: • The PIC has updated the statement of purpose to reflect current Avista policy	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • The register provider has scheduled a dated to complete upgrading of the kitchen facilities. • The register provider has schedule maintenance to review laundry facilities.	

Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • The PIC has ensured that all doors closure measures are maintained as per Avista fire policy. • An independent fire safety company completed an assessment on the location of fire equipment. PIC has ensured that that their actions are in place.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • The Provider will ensure that Behaviour Support Services are provided by appropriate MDT members.	

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 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff 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.	Substantially Compliant	Yellow	15/12/2023
Regulation 21(1)(a)	The registered provider shall ensure that records of the information and documents in relation to staff specified in Schedule 2 are	Not Compliant	Orange	15/10/2023

	maintained and are available for inspection by the chief inspector.			
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	15/11/2023
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	25/09/2023
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	25/09/2023
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	25/09/2023
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed	Substantially Compliant	Yellow	15/12/2023

	consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.			