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:	Kare DC20
Name of provider:	KARE, Promoting Inclusion for People with Intellectual Disabilities
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	15 November 2023
Centre ID:	OSV-0001982
Fieldwork ID:	MON-0036831

About the designated centre

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

This designated centre is a bungalow in a rural location on the outskirts of a town in Co. Kildare. The house accommodates two adult residents and contains a living room, a kitchen and dining area, utility room and four bedrooms, and two bathrooms with shower and toilet facilities. There is a lawn with shrubs to the front of the house and a patio area with large garden space to the back of the house. The person in charge of this service, who splits time with one other designated centre, leads a team of social care staff employed by the registered provider. A vehicle is available to drive residents to and from different activities and the local community.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 15 November 2023	11:10hrs to 18:30hrs	Gearoid Harrahill	Lead

What residents told us and what inspectors observed

During this inspection, the inspector had the opportunity to meet and speak with the residents and their direct support staff team. The inspector observed routines and interactions in the residents' day, and observed the home environment and support structures, as part of the evidence indicating their experiences living in Kare DC20. This inspection was unannounced and residents were introduced to the inspector and advised what the purpose of the day was, before they returned to their preferred routines.

Residents were supported by a team of staff who were familiar with residents' interests, support needs and personalities. The inspector observed a relaxed atmosphere and encouraging rapport between residents and their staff, while residents were also reminded about being patient and speaking to people with respect when asking for things or calling for support. Residents were observed relaxing on the couch, making themselves coffee, using their computer and enjoying music, videos and games online. At the time of this inspection one resident was reluctant to go outside and into the community following a fall injury, with staff describing how they were supporting them to be reassured to do so and reengage with their routines.

While neither resident attended education placements or day services, one resident had paid employment two days a week and regularly attended a gym. Staff described new social and recreational opportunities being tried out to encourage resident engagement, with a recent example being an enjoyable cinema trip. One resident went home to spend time with family as a regular part of their routine. Residents had some personal goals chosen related to travel, big shopping trips, and new social and employment opportunities, however the staff guidance and work done as steps to support achievement of these goals was not clear. The provider had a section in their quality and safety reviews to reflect the collected input and commentary on the residents' experiences living in the house, however the evidence of this was limited.

The house layout was suitable for the number and needs of residents and furnished in line with their personal preferences. Some areas of the house were in need of repair, updating or redecoration, in particular the house kitchen. Residents had the option of locking their bedroom for their own privacy, and had a secure space in which to store their valuables. Residents were supported to spend their money as and when they liked in shops and cafés and online.

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.

Capacity and capability

The designated centre was resourced with an experienced and well-established staff team who demonstrated a good knowledge of the residents and their interests, wishes and personalities. The management had means of ensuring that staff were alerted to mandatory training or refresher courses in which they were outstanding, and was overseeing a new member of staff completing this.

The provider had a full team of staff in this centre with suitable contingency arrangements to cover staff leave and shift gaps. The provider maintained a worked roster which clearly indicated personnel and shift patterns in the centre.

Development was required in the audits and quality and safety reports conducted in the centre to ensure they reflected areas for improvement as identified in the general operation of the centre, as well as how these quality of service reports incorporated the feedback, experiences and satisfaction of the service by the people who lived in the designated centre. Some actions set by the provider in response to their own audits and previous regulatory inspection had not progressed per the set timeline or were observed to be outstanding on this inspection.

In the main, records and documentation related to the residents and the centre operation were kept in the designated centre and readily available for review during this inspection.

Regulation 15: Staffing

Residents were supported by a well-established core team of staff delivering patient and respectful support. The provider had access to sufficient relief staffing resources to ensure that shifts were covered during absences and vacancies.

Judgment: Compliant

Regulation 21: Records

Records were maintained and available for inspection in this designated centre.

Judgment: Compliant

Regulation 23: Governance and management

The designated centre was appropriately resourced with staffing and management personnel, and staff commented that they felt appropriately supported to carry out their duties.

The provider had composed an annual review of this service dated November 2022 in which the provider found themselves to be in compliance with the majority of the requirements of regulations and provider policies. The inspector observed limited evidence in this review to indicate that it had been written in consultation with the residents.

The provider had carried out an unannounced inspection in January 2023, the findings of which informed a timebound action plan to address improvement or deficits in the service such as resident support objectives, completion of mandatory training by staff and risk assessments being kept under timely review.

Neither the annual review nor six-monthly quality report identified or set out time frames for addressing maintenance and repair issues around the house which had been identified through the centre maintenance log or on the previous regulatory inspection, for example repair works required in the kitchen and bathroom areas. Neither report referenced outstanding issues related to fire safety, such as the use of key-locked doors or areas in which the provider was not assured of fire safety. A number of the regulatory findings from the previous inspection in October 2021 were identified again on this inspection, and had not been addressed in line with the provider's own timelines following that report.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The terms and conditions of living in this centre were agreed in writing between the residents and the registered provider.

Judgment: Compliant

Regulation 31: Notification of incidents

The provider had notified the Chief Inspector of Social Services of adverse incidents and allegations which had occurred in this centre.

Judgment: Compliant

Regulation 4: Written policies and procedures

Policies and procedures required under Schedule 5 of the regulations were available for review in the service. However, not all aspects of the policies had been implemented in practice, or had not been updated to reflect relevant national standards and guidance.

Judgment: Substantially compliant

Quality and safety

In the main, residents' health and personal support needs were being met and they were protected from potential or actual safeguarding risk. While some support plans and staff guidance required review to ensure they reflected the most recent information and assessments, staff had a good personal knowledge of the residents and their support needs.

As will be described in later sections of this report, some areas of the premises were not in a good state of repair or required repainting, maintenance work or more complete cleaning. While the deficits observed did not create a risk of injury, they negatively impacted on the pleasant aesthetic of the residents' home, or on the ability to clean and sanitise parts of the environment.

The provider had works scheduled for December 2023 to upgrade internal doors along evacuation routes to provide effective containment of fire and smoke, and for this to be done in a manner which would not require the residents to move out of their home. Other risks related to fire, such as the potential of residents not evacuating, assurances around detection and protection features, and risk controls for gates and doors locked with keys were observed during this inspection which required attention. The provider advised that an external fire risk assessment would be commissioned in 2024 to provide this assurance or inform any further action.

The provider had initiated some plans to gather evidence to inform revision of restrictive practices in the house, with a view to reducing or discontinuing long-standing risk controls to a level more appropriate as a last resort to the current assessed risk. Data was collected to inform some of these reduction plans earlier in 2023, however it was not clear what was being done with the information gathered to reassess measures as being the least restrictive option.

Regulation 12: Personal possessions

The inspector observed evidence to indicate that residents had access, either alone or with staff support, to their property and finances. Residents were facilitated to use their money and bank cards to order food when out to lunch, do online shopping, buy what they wanted in shops and subscribe to online services. Cash and cards were stored securely, but using a means by which residents could access themselves.

Judgment: Compliant

Regulation 17: Premises

The inspector observed areas of the house which were not in a good state of repair or cleanliness on inspection. Examples of these included, but were not limited to, the following examples:

- Kitchen cabinets were damaged, worn, peeling or had broken hinges from wear and tear. Units and kickboards were observed to be rotten or water damaged
- Paintwork was cracked or flaked on internal and external walls of the house
- Radiators, bathroom fixtures and support rails were observed to be rusted
- There was a build-up of moss along external support rails
- High surfaces and ceiling extractor fans were observed to be thick with dust
- A shower area was dirty with build-up of black grime
- The floor was lifting and peeling in a storage area

With the exception of the kitchen units, the above examples of areas requiring repair, replacement or repainting had not been recorded in the centre maintenance log.

Judgment: Not compliant

Regulation 18: Food and nutrition

In response to concerns related to safety while eating, the speech and language therapist had conducted a timely review of residents' FEDS (feeding, eating, drinking and swallowing) assessments. From this review, staff has readily available guidance to support residents to remain safe and independent at meal times.

Judgment: Compliant

Regulation 26: Risk management procedures

Some assessments, ratings and control measures had not been reviewed or revised to reflect changes in the service, trends of incidents or data collection, or new risks which had been identified by the provider and centre management.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Cleaning materials and tools were not observed to be stored in a manner which was suitable to avoid contamination. The inspector observed that mop heads were not laundered on a regular basis.

Some areas of the house were not equipped to facilitate effective hand hygiene by staff and residents. For example, areas for washing hands did not all feature appropriate hand towels, pedal bins, or hot water supply to taps.

Surfaces which were worn, rusted, peeling or damaged did not facilitate effective cleaning and sanitising of surfaces in kitchen and bathroom areas.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had not progressed plans to mitigate risks associated with having key-locked doors and gates along fire evacuation routes.

The provider was on track to upgrade internal doors along evacuation routes in this house in December 2023, to ensure they were sufficient to contain fire and smoke, in accordance with a provider-wide project for multiple houses previously provided to the Chief Inspector.

The inspector observed a sitting room door onto the evacuation corridor to be locked, requiring a key. This created a risk of someone in this room being trapped if the fire started in the adjoining kitchen. This door was unlocked when brought to the attention of the person in charge.

The staff and management could not provide assurance of the fire safety of the building, for example they were not sure if the attic space was equipped with a means of detecting fire or smoke, or if the door to same would protect the

evacuation route. The provider advised that a full fire risk assessment by a competent expert would be carried out on this house in 2024.

The provider had conducted practice evacuation drills in the service, however the records of these drills did not provide assurance that a consistent and efficient evacuation could be carried out. While the provider had conducted a drill at night, this took place at 9:10pm when staff and residents were in communal areas. As such this did not evidence how the provider was assured of how long it would take to evacuate this house, in which staff are asleep at night. In a recent drill, one resident refused to leave the house and the drill was cancelled. The risk assessment and emergency plan related to supporting this person had not been updated to reflect this finding, and advise staff what to do in response to this risk.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Resident prescription sheets clearly outlined the times, doses and reasons for administering regular and as-required medicines. The administration sheets available for review indicated that staff were administering medicines in line with how they were prescribed for each person. Medicines were in stock and appropriately stored.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

In the main, support plans were person-centred, based on evidence and multidisciplinary input. However, some plans had not been updated to reflect the latest recommendations from reviews and assessments and contained obsolete information, for example when specialist care plans or risk control measures had been changed or discontinued. It was not evident that the residents' participation in the development and review of plans was being optimised in a manner with which they could engage. Some personal, social or life enhancement goals such as gaining employment, healthy living, or travelling, were identified but without specific or measurable steps to support staff and residents to achieve these objectives. The provider had identified this as an area for improvement following its own most recent quality audit.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

A number of environmental restrictive practices were in use in this designated centre as risk controls for some resident behaviours. The majority of these practices had been in effect for a number of years, however not all measures were identified and reviewed as restraints on the centre's restrictive practices register. No risk assessment had been carried out to assess the impact restraints had on residents' rights For residents who were affected by restraints related to risks presented by other people, it was not evident how the risk of having the restraint was assessed.

The provider had identified two active restrictions for which there had been a trial period of reducing the practice. Staff had recorded notes on whether the trialled reduction had resulted in continued risk. However, one trial period was completed without incident of the relevant risk, and the assessed risk level remained low, yet the practice remained unchanged with no notes as to why. In a trial reduction of another risk, information recorded by staff did not provide measurable evidence for the provider to conclude whether or not the trial was successful. There was no evidence to indicate alternatives considered or reduction plans for other restrictions in the house.

Following this inspection, the registered provider advised that centre policies on restrictive practices had been updated in 2023, however the policy used in the designated centre was dated June 2020 and did not incorporate current national standards and guidance. A number of aspects of the provider policy had not been implemented in practice. Examples included setting out plans aimed at reducing restraints at the earliest opportunity, attaining consent from residents and including them in assessments, ensuring each restraint was proportional to the assessed level of risk, and analysing data and trends to assess if each practice remained the least restrictive option to mitigate the related risk. The provider policy also described a restrictive practices monitoring group consisting of psychology and senior management personnel, to oversee the use of restrictive practices, however the inspector observed no evidence of review by this group.

Judgment: Not compliant

Regulation 8: Protection

The inspector observed that the provider was taking appropriate action to protect residents from harm or poor standards of support. Allegations or witnessed incidents were investigated in a timely fashion, and disciplinary or safeguarding action was taken as required.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Kare DC20 OSV-0001982

Inspection ID: MON-0036831

Date of inspection: 15/11/2023

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The provider updated the annual review of this service in December 2023 and in this review, documented evidence to indicate that it had been written in consultation with the residents. This was published in January 2024. The provider has a plan of completing a stock condition assessment across the property portfolio in 2024. This assessment will ensure that all identified current and future issues related to the physical structure of the buidling will be considered, planned for and scheduled for budget allocation. This will form part of an overall ten year property plan. The stock condition survey for this location will be completed by 31st of December 2024. The planning to address and schedule the actions will be completed by the end of quarter 1 2025. An improved process for identifying actions required to address maintenance and repair issues as part of the aduit process was agreed with the facilities department in January 2024. This will commence from January 2024 and include regulations related to fire management, infection prevention and control as well as premises. A review of all outstanding actions noted for this location was conducted on the 15th of January 2024 and outlined under premises regulation in this action plan report. A review of Kare's audit template will be completed by the end of February 2024 and changes made to improve the process in line with the updated judgement framework documentation when launched by HIQA.	
Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The restrictive practice policy was reviewed in line with National guidance in September 2023 and launched to staff across the organization. This policy is available to view of Kare Connect the internal Sharepoint database. All staff on induction and regularly throughout their employment with Kare are reminded that they must access policies from this site only as they are the current and live policies.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Kitchen cabinets – replacement scheduled for completion by the end of September 2024.
• Paintwork on internal and external walls of the house will be completed by the end of April in 2024 in areas required.
• Radiators, bathroom fixtures and support rails – will be painted or replaced by the end of February 2024.
• Bathoom replacement will be completed by the end of September 2024.
• external support rails will be cleaned by the end of February 2024.
• High surfaces and ceiling extractor fans will be cleaned appropriatley by the end of January 2024.
• A deep clean will be completed by an external company which will address required areas including the shower area by the end of February 2024.
• The floor will be replaced by the end of February 2024.

Updating cleaning checklist to include areas that require to be scheduled on a regular basis will be implemented from the end of January 2024.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The location risk register in Kare is in the process of transitioning to an electronic format by the end of February 2024 from its current word/Excel format. A support team has been provided to the staff in this location to identify any assessments, ratings and control measures that are required to be included or changed as part of this process. This will be completed prior to the 29th of February 2024.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
New storage container for mops, cleaning materials and tools will be in place by the end of February 2024.
Mop heads are laundered on a regular basis, these are included on cleaning checklist by the 23rd of January 2024.
The provider is going to install holders for paper towels and provide suitable bins in required areas by the end of February 2024.
Hot water supply to taps in bathroom in this location was addressed on the 5th of January.
Surfaces which did not facilitate effective cleaning and sanitising of surfaces in kitchen and bathroom areas will be addressed by the end of September 2024

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Thumb lock doors will be installed on the two side exits along fire evacuation routes by the end of March 2024.

Fire doors with automated closures have been installed in this location as per schedule in December 2023.

A full fire risk assessment by a competent expert will be carried out on this house in 2024. This location will be prioritized in risk assessment review.

The attic space is monitored by an alarm monitoring system as a means of detecting fire or smoke.

The attic hatch will be replaced with fire proof material by the end of March 2024.

The provider has conducted practice evacuation drills in the service. A fire drill was conducted on the 13th of January 2024 which was successful. A record of this drill is documented on CID database.

The PEEPs for one individual was updated on the 11th of January 2024 to include

additional supports that may be required in the event of an evacuation.

A fire drill at night will be scheduled to occur prior to the end of January 2024.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Plans are in the process of being updated to reflect the latest recommendations from reviews and assessments. Any obsolete information will be archived. This will be completd by mid February 2024.
The residents' participation in the development and review of plans will be updated to reflect their engagment.
Some personal, social or life enhancement goals such as gaining employment, healthy living, or travelling, were identified and are now documented on CID database. Specific or measurable steps to support staff and residents to achieve these objectives have been identified. This will be completed by mid February 2024.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The locations restrictive practices register will be updated to reflect the actual practices in place by the end of January 2024.

A risk assessment to assess the impact restraints may have on residents' rights was completed on the 15th of January 2024.

The trial period for restrictive practice was discontinued due to an adverse event.

The fencing at the front of the house has been repaired as of the 12th January 2024.

The planned second week of the trial for the removal of a restrictive practice in this location has been scheduled for the 29th of January 2024 for one week period. This will be planned at the staff team meeting on the 23rd of January 2024. The outcome will inform the next steps.

The provider will review the other restriction in the location with the aim to remove the restriction. This will be completed by a trial period of one week in March 2024. Measurable evidence will be documented so the team can conclude whether or not the trial was successful.

The clinical psychologist will be involved in the review. This has been discussed on the 16th of January 2024.

The restrictive practice policy was update in September 2023 and launched to the staff team. The restrictive practice oversight committee has recorded minutes of their meetings on Kare Connect. The terms of reference for the group was updated in September 2023.

All staff will be provided with access to the files for the Restrictive practice oversight group in January 2024.

A further review of the restrictive practice policy is scheduled for 2024 and will be updated and launched to staff by the end of December 2024.

A new email for the restrictive practice oversight group was set up on the 11th of January. This was communicated to all staff in Kare on the 16th of January 2024.

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(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	Orange	30/09/2024
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	30/09/2024
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/03/2025

Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	31/12/2024
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	29/02/2024
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	Orange	30/09/2024
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including	Not Compliant	Orange	31/12/2024

	emergency lighting.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	29/02/2024
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	31/12/2024
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	30/09/2023
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the	Substantially Compliant	Yellow	20/02/2024

	resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.			
Regulation 05(4)(c)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which is developed through a person centred approach with the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Substantially Compliant	Yellow	20/02/2024
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Substantially Compliant	Yellow	20/02/2024
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical,	Not Compliant	Orange	31/03/2024

	chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Substantially Compliant	Yellow	31/12/2024
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	31/12/2024