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:	Grangemore Rise
Name of provider:	St Michael's House
Address of centre:	Dublin 13
Type of inspection:	Unannounced
Date of inspection:	28 January 2022
Centre ID:	OSV-0002341
Fieldwork ID:	MON-0033349

About the designated centre

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

Grangemore Rise is a designated centre operated by St Michael's House. The centre is located in North County Dublin. It provides community residential services for up to seven residents, over the age of 18 years, with intellectual disabilities and with support needs. The designated centre consists of a house and a detached apartment located to the rear of the house. The house is a two storey building and provides accommodation for up to six residents and consists of a storage room, toilet, utility room, kitchen, dining room/living room, two bathrooms, two offices and six individual bedrooms. The apartment is home to one resident and consists of a kitchen, living/dining room, utility room, staff room, bathroom and bedroom. The designated centre is located close to local shops and transport links. The centre is staffed by a person in charge and social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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 28 January 2022	09:30hrs to 17:30hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

In line with public health guidance, the inspector wore personal protective equipment (PPE) and maintained social distancing during interactions throughout the day. The inspector used conversations with residents and staff, observations and a review of the documentation to inform judgments on the quality of care in the designated centre. Overall, the inspector found that residents were living in a home which was striving to provide good quality care in a manner which met the residents' assessed needs.

The inspector had the opportunity to meet with several residents on the day of inspection. Some chose to speak in more detail regarding their experiences of living in Grangemore Rise. Residents spoke positively about their home and the support that they received from staff. Residents told the inspector that they were supported to take part in activities, employment and further education in their community as per their individual preferences. One resident said that they received support from the provider to access support services such as counselling when required. Another resident told the inspector that staff listen to them and help them. This resident told the inspector that when they had made a complaint, that this complaint was responded to and that they were happy with the outcome.

The inspector saw that the house was clean and comfortable. Residents were supported to complete activities in line with their individual preferences. One resident was getting ready to go to the gym on the morning of inspection. Two other residents were at day services and one resident chose to have a lie in. The atmosphere in the house was calm and relaxed. It was evident that issues with peer compatibility, as identified on previous inspections, had been resolved following the transition of one resident to an individualised service in a different designated centre. The inspector also noted that the provider had not filled the vacancy in the centre and was informed by the person in charge that careful consideration and planning would be required, in line with their admissions policy, before any new residents would move in to the house.

Staff were observed to interact with residents in a gentle and supportive manner. Staff were seen to be responsive to residents' communications including those who communicated through non-verbal means. Staff spoken with were knowledgeable regarding residents' assessed needs.

Overall, the inspector saw that the residents in this centre were supported to enjoy a good quality of life. The registered provider, person in charge and staff were striving to provide person-centred care in a comfortable and homely environment.

Capacity and capability

This inspection was an unannounced risk inspection, the purpose of which was to monitor ongoing levels of compliance with the regulations. The last inspection of the designated centre, in April 2021, identified that ongoing peer compatibility issues were having a significant impact on the quality of life of residents. The provider subsequently committed, through their compliance plan, to sourcing alternative accommodation for one resident. The current inspection aimed to follow up on the provider's compliance plan and verify that actions had been completed.

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. Overall, the inspector found that residents were in receipt of a person centred service. However, improvements were required to the oversight mechanisms to ensure that service quality continued to be driven in a meaningful and achievable manner.

The inspector was informed that the centre was operating with one vacancy at the time of inspection. The person in charge had in place a panel of relief and agency staff in order to compliment the roster. A review of the roster found that there was a significant reliance on relief and agency staff. In January 2022 there were as many relief staff on the roster as there were regular staff. This was attributed to some staff working part-time, as well as leave required due to suspected cases of COVID-19 amongst staff. The high reliance on relief staff did not support continuity of care for residents.

The inspector saw that, on one day in January, the staffing complement was not as prescribed due to several staff being on COVID-19 leave. While assurances were provided that residents were appropriately supported that day, it was evident that there was insufficient oversight of the staff roster. The roster was also not properly maintained. On one day, it was not clear which staff were allocated for night duty. Night duty staff had been assigned on a previous working copy however when this was amended, the most recent working copy was not updated correctly to reflect the changes.

A training matrix was maintained which demonstrated that all staff were up-to-date in training in Children First, Safe Administration of Medications (SAMs) and feeding, eating, drinking and swallowing (FEDS). There were some gaps in training which was required to be delivered face-to-face including in fire safety and first aid. The inspector was informed that dates had been secured for most of these trainings for the coming weeks.

A risk was identified by the inspector whereby staff did not have access to all trainings as required by residents' individually assessed needs. For example, some residents' support plans stated that the residents communicated using multi-modal communication including Lámh and picture exchange communication (PECS). However staff in the designated centre did not have access to trainings in these areas. The inspector was informed by staff that one resident communicates nonverbally by leading staff to items that they want. The staff told the inspector that

this resident may have used PECS in the past but they were unsure if the resident continued to use PECS. Additionally, a review of the incidents log identified that there had been several incidents of challenging behaviour where a staff had been physically hurt by a resident. While staff in this centre had access to training in behaviour that is challenging, they did not have access to specific training in responsive practices to physically aggressive behaviour. This had not been identified as area of need or for service improvement on the centre's biannual or annual audits.

There were clear reporting structures in place in the designated centre. The centre was staffed by a full-time person in charge who was supernumerary to the roster. The person in charge reported to a service manager. Staff spoken with were aware of who the shift lead was for the day and of their roles and responsibilities.

The provider had in place several audits in order to monitor and review the quality and safety of care in the service. These audits included monthly data reports, health and safety audits, six monthly audits and an annual review. However, on review, these audits were found to not be specific to the designated centre and did not comprehensively reflect the risks present. For example, the annual review from 2021 referenced another designated centre in the "consultation with families" section and the monthly data reports did not account for all of the residents in the centre.

Furthermore, the goals identified arising from these audits were not specific and it was not clear how they were driving quality improvement. For example, a goal from the annual review in 2021 was to commence outcome reviews when meetings could be held in line with COVID-19 restrictions. This was not specific, measurable or time-bound and the provider had not established any additional ways that this goal could be achieved in line with restrictions such as the use of video or teleconferencing.

A review of the centre's incidents log identified that incidents were notified to the Chief Inspector in line with the requirements of the regulations. The provider had enacted a complaints policy which was in date and a complaints procedure was available in the entryway of the centre. There was evidence that the provider had responded to complaints in 2021 in line with their policy and that, where residents had made complaints, that they were assisted to understand the complaints procedure as well as the outcome of the complaint.

Regulation 15: Staffing

There was insufficient oversight of the roster, in particular in relation to planning for continuity of care for residents due to staff working part-time or being on leave. The centre was operating with one vacancy and had several staff working part-time. While contingency plans for staffing were in place, they required strengthening to ensure that there were sufficient, familiar staff on duty at all times to meet the

assessed needs of residents. A planned and actual roster was maintained however there were gaps in the roster due to the multiple changes and versions available.

Judgment: Substantially compliant

Regulation 16: Training and staff development

While many staff were up-to-date in several key training areas, there was a delay in staff accessing refresher training in trainings which were required to be delivered face to face. The outstanding trainings were:

- fire safety: two staff required this
- first aid: 6 staff required this

It was not evident that staff had received training in all areas required to meet the needs of residents. Some residents were described as using multi-modal communication in their care plans however staff had not received training in this area. Additionally, a risk was identified whereby staff had been hurt during incidents of challenging behaviour by residents. The inspector was informed that staff did not have access to specific training in responding to physical behaviour.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had in place good local reporting structures and management arrangements. The provider had also responded effectively to previously identified risks in the centre including peer compatibility issues. There were a number of audits in place to enhance oversight of the service however improvements were required to these to ensure that they were specific to the designated centre and comprehensively reflected the risks presents. Goals arising from audits required enhancement to ensure that were specific, time-bound and measurable.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A review of the centre's incident log book demonstrated that notifications were submitted to the Chief Inspector in line with the requirements of the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had effected a complaints policy and had made available and accessible version of the complaints procedure. A review of the complaints log book identified that complaints were investigated promptly and in line with the provider's policy. Complainants were assisted to understand the complaints procedure and the outcome of their complaint.

Judgment: Compliant

Quality and safety

This section of the report details the quality and safety of the service and how safe it was for residents who lived in Grangemore Rise. Overall, the inspector found that residents were in receipt of a safe and person centred service which was respectful of individual rights and preferences. However, enhancements were required to the oversight of goal setting and progression of goals for all residents which had been delayed due to COVID-19 restrictions.

The inspector saw that the designated centre was generally clean and well maintained. Residents had access to two sitting rooms and a conservatory. Each resident had their own bedroom which was decorated in line with individual preferences and equipped with assistive equipment as per their assessed needs.There was some minor painting required in high traffic areas in the main house such as hallways and doors. One resident also had a broken dresser in their bedroom which required replacing. The resident in the apartment showed the inspector around their home. The inspector noted that their home was very clean and well personalised. The resident showed the inspector that there was some mould in the corner of their bedroom and around their front door. The resident stated they had informed the person in charge and that this was in the process of being addressed.

The provider had implemented procedures to protect residents from acquiring a healthcare associated infection. Staff were observed wearing appropriate personal protective equipment and socially distancing, where possible. Temperature checks were completed on arrival to the centre. There was a COVID-19 contingency plan which was regularly reviewed as well as a COVID-19 house plan. COVID-19 risk assessments were also on file for each resident. There were generally adequate hand hygiene facilities around the centre however there was one identified risk whereby a hand soap dispenser in a main bathroom was empty.

A review of resident files demonstrated that all residents had an assessment of need completed which was updated within the last 12 months. Assessments of need were used to inform care plans for residents. Care plans provided the facility for these to be reviewed quarterly by keyworkers however it was not evident that this was done as these were not signed off on.

The majority of residents had a 'My Life' meeting held in the past 12 months. Goals were set from these meetings and a goal tracker was in place to monitor achievements. It was found that goal trackers were not always completed and so it was not clear what steps had been taken towards achieving some goals. For example, one resident had set a goal of ''trying new things'' for 2021-2022 however the goal tracker was blank. Two residents had not had the opportunity to participate in a recent 'My Life' meeting with their representatives. The delay in holding these meetings was attributed to COVID-19.

Residents had access to appropriate health care in line with their personal plans. Residents were supported to access general practitioners, hospital consultants and multi-disciplinary professionals as per their assessed needs. Residents' rights to refuse treatment to specific interventions was also documented and respected. One resident had recently been admitted to hospital due to an acute illness. This resident's file was reviewed and it was found that the provider had sought appropriate care and had advocated for appointments to be expedited in light of the resident's health needs. The person in charge had also ensured that the resident was supported by familiar staff during their hospital stay and maintained communication between the designated centre and the hospital.

There were up-to-date behaviour support plans on file for those residents who required them. There were several restrictive practices in place in the designated centre however these had been approved by the provider's rights committee. Restrictive practices were notified to the Chief Inspector in line with the regulations. Staff spoken with were aware of restrictive practices and of the behaviour support plans in place to support these. While staff had access to training in positive behaviour support, they had not received training in intervention techniques for managing behaviour that is challenging. This resulted in several incidents where staff received minor injuries subsequent to an incident of challenging behaviour.

The registered provider had taken measures to ensure that residents were protected from abuse. Peer compatibility issues had largely resolved since one resident had transitioned to an individualised service. Where incidents did occur, these were recorded, investigated and notified to the relevant statutory bodies. Safeguarding plans were implemented as required and residents had up-to-date intimate care plans available on their files. Intimate care plans were written in person centred and respectful language and detailed steps to support residents' dignity and autonomy.

Residents in the centre appeared to be well supported to access opportunities both in-house and in the community for occupation, recreation and employment. Residents spoke about their preferred activities and were observed coming and going from the centre on the day of inspection. The house meeting minutes were reviewed and it was clear that residents availed of multiple community outings

including going for shopping, out for dinner, gardening and for various day trips. There was evidence that the provider had endeavoured to support one resident to trial a new day service as per their identified goal. This resident told the inspector that they had tried the day service but did not like it and chose to have a day service from home instead. The provider had put in place measures to support this preference.

Regulation 13: General welfare and development

Residents had access to facilities for occupation and recreation and were supported to participate in activities in accordance with their interests, capacities and needs. Residents frequently accessed the community for both socialisation and for employment.

Judgment: Compliant

Regulation 17: Premises

The designated centre was designed and laid out to meet the needs of residents. It was clean and suitably decorated and generally well maintained. There were some identified premises issues which included:

- painting of high traffic areas in the main house
- replacement of a broken dresser in one bedroom
- treatment of mould in the apartment

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had implemented policies and procedures to protect residents from acquiring a health care associated infection. Staff were wearing appropriate PPE and there were adequate contingency plans in place should there be an outbreak of COVID-19. Improvements were required to the oversight of all hand hygiene stations to ensure that these were sufficiently stocked.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

All residents had a recently updated assessment of need and most residents had been supported to engage, through a person centred approach with their representative, in developing personal plans.

However, enhancements were required to the oversight and monitoring of care plans and goal progression. Two residents had not had the opportunity to participate in a recent 'My Life' meeting in order to develop their personal plans. While the provider attributed this to COVID-19, it was not clear that the provider had made alternative arrangements for progressing personal plans in light of the restrictions of the pandemic.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to appropriate health care as per their assessed needs. The person in charge sought medical treatment for residents and facilitated access to appointments as required. The resident's right to refuse medical interventions was also documented and respected.

Judgment: Compliant

Regulation 7: Positive behavioural support

Behaviour support plans were on file which had been recently reviewed. Staff had access to training in positive behaviour support however it was not clear that they had sufficient training in intervention techniques in order to manage all incidents of challenging behaviour. Restrictive practices which were in place had been approved by the provider's rights committee and were regularly reviewed. Restrictive practices were also notified to the Chief Inspector in line with the regulations

Judgment: Substantially compliant

Regulation 8: Protection

The provider had implemented appropriate policies and procedures to ensure that residents were protected from abuse. Staff had completed training in safeguarding

and Children First. Allegations of abuse were recorded and notified to relevant statutory bodies and safeguarding plans were implemented.
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	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Grangemore Rise OSV-0002341

Inspection ID: MON-0033349

Date of inspection: 28/01/2022

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 provider is recruiting staff at present. The Designated centre will be assigned a suitable staff to meet the service user's needs. (30.06.22) • There is a contingency plan in place which contains a list of Relief/Agency staff that is familiar with the residents needs in the designated Centre. This is to ensure continuity of care in the event of unforeseen sick leave. This list is available for review.	
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 Person in Charge has reviewed the training matrix with the training department. Staff have completed all online training and face to face training has been booked in accordance to the guidance regarding Covid -19. • The person in charge has reviewed each PEP and amended each plan to reflect the resident's needs and communication methods. PEP's are available for review. (26.02.2022) • The Person in Charge has liaised with the designated centre psychologist, at this time it is not deemed necessary for staff to be trained in specific training in responding to physical behaviour (18.02.22). PIC will ensure all Staff have completed training in Positive behaviour Supports. (30/06/2022)	

Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The Service Manager and Person in Charge reviewed audits to ensure that they were specific to the designated centre (22.02.2022). • Person in Charge reviewed and discussed the goals outlined in the Annual Review with the residents. New goals/achievements were set for 2022. (22.02.22) • Monthly data will be reviewed to include all residents residing in the designated centre. (30.03.22)	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • Person in Charge supported resident to replace a broken dresser in the bedroom. This will be delivered on the (02.03.22) • Person in Charge will source a quote and seek approval from the organisation to paint the high traffic areas. Works will be completed by 30.06.22 • Person in Charge purchased a dehumidifier (27.03.22) and has contacted the Technical Service Department in relation to the mould in the apartment.	
Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: • The Person in Charge has updated the cleaning rota to ensure that hand hygiene stations have sufficient stock. (15.02.22)	
Regulation 5: Individual assessment	Substantially Compliant

and personal plan	
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: • The Person in Charge will ensure all residents will be supported to have a "My Life" Meeting and meaningful goals in accordance to their wishes. (20/04/2022) • The Person in Charge will ensure all goal progression will be recorded on the goal tracker. (Immediately)	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • The Person in Charge liaised with the designated centre psychologist, at this time it is not deemed necessary for staff to be trained in specific training in responding to physical behaviour (18.02.22). PIC will ensure all Staff have completed training in Positive behaviour Supports (PBS).	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	30/06/2022
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	30/06/2022
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota,	Substantially Compliant	Yellow	01/02/2022

	showing staff on duty during the day and night and that it is properly maintained.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/06/2022
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.	Substantially Compliant	Yellow	30/06/2022
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	30/03/2022
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care	Substantially Compliant	Yellow	22/02/2022

	and support is in accordance with standards.			
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	30/03/2022
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.	Substantially Compliant	Yellow	15/02/2022
Regulation	The person in	Substantially	Yellow	20/04/2022

05(4)(c)	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.	Compliant		
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	18/02/2022
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	30/06/2022