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:	Royal Oak
Name of provider:	St Michael's House
Address of centre:	Dublin 9
Type of inspection:	Announced
Date of inspection:	28 January 2025
Centre ID:	OSV-0002361
Fieldwork ID:	MON-0037183

About the designated centre

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

Royal Oak is a designated centre based in a North Dublin suburban area and is operated by St Michael's House. It can provide community residential services to three male residents with intellectual disabilities over the age of 18. The designated centre is comprised of two attached houses with an internal door for access. The designated centre currently consists of two residents' bedrooms, a multi-purpose room, a staff bedroom and spare en-suite room. There are also two kitchen come dining rooms, two sitting rooms, an office, two bathrooms and two toilets. There is a garden to the rear of the centre which contains two small buildings which are used for laundry and storage. The centre is located close to amenities such as shops, cafes and public transport. The centre is staffed by a person in charge and social care workers. Staff have access to nursing support through a nurse on call service.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 28 January 2025	10:30hrs to 18:00hrs	Jacqueline Joynt	Lead

What residents told us and what inspectors observed

The purpose of this inspection was to inform decision making regarding the registration renewal for this designated centre.

The inspector used observations alongside a review of documentation and conversations with key staff and management to inform judgments on the residents' quality of life and the provider's compliance with the regulations. The inspection was facilitated by the person in charge for the duration of the inspection. The person participating in management joined the inspection for feedback at the end of the inspection.

At the time of the inspection there were two residents living in the centre, with one vacancy. Residents were supported to have active lives. On the day of the inspection, residents were engaging in different activities that were meaningful to them. One resident attended their day service and another resident attended their place of employment. The inspector briefly met with one of the residents at the beginning on the inspection and again at the end of the inspection. The resident was happy to greet the inspector on both occasions however, did not relay their views about living in the designated centre. The other resident declined to meet with the inspector on the day however, was happy for the inspector to review any documentation related to their care and support. The person in charge and staff also advocated on behalf of both residents.

The provider's current annual review had ensured that residents (and their representatives) were consulted with and given the opportunity to express their views on the service provided in the centre. Further feedback had been sought from residents and family for the provider's upcoming annual review which was still in progress at the time of the inspection.

In advance of the inspection, residents were each provided with a Heath Information and Quality (HIQA) survey, where they could relay what it was like to live in their home. The two residents chose to complete the surveys with the support of their family. One survey relayed positive feedback regarding the quality of care and support provided to the resident living in the centre. However, the other survey relayed less positive feedback and primarily responded to most sections that the service they received 'could be better'. In addition, the survey relayed areas that they were unhappy about and where they felt there was areas for improvement.

For example, the survey noted that the resident's room was very small, that it was a box room and not suitable to the age and height of the resident and that there was "no space to move". The resident relayed (through the support of their family) that they would like to live in a house where they had a good relationship with the person they lived with. In relation to the supports staff provide section of the survey, the residents noted that "it could be better". The resident did note however, that they could make their own choices and decisions and that they could go out for

trips, visits and events.

The other survey relayed that the resident found the centre was a nice place to live in and that they liked the food and had their own bedroom. The feedback from the resident mentioned they felt staff knew what was important to them and were familiar with each of their likes and dislikes. The survey relayed that staff provided help to the resident when they needed it. In response to the question asking if they got along with the person they lived with, the residents noted "it could be better".

On the day of the inspection, the inspector was informed that both residents rarely interacted with each other. However, if they did spend time together in the same room, to mitigate the risk of a safeguarding incident, a staff member would supervise from a distance. The person in charge informed the inspector that there was a provisional plan, which was at discussion stage, for one of the residents to move to a, yet to be built, on-sight self-contained apartment. However, this was at a very initial stage and would not be able to progress until the outcome of the planning permission was received.

A resident had made a complaint on several occasions about issues they were not happy with. The resident often met with the person in charge and talked about any issues they had. There was an open complaint at the time of the inspection, which relayed a resident's unhappiness about an ongoing specific staffing arrangement, this is discussed further in the report.

The person in charge accompanied the inspector during an observational walk-around of the centre. Overall, the inspector observed the centre to be welcoming and homely and it was clean and tidy and for the most part, in good upkeep and repair. The centre comprised of two attached houses with an internal door for access. The designated centre consists of two kitchen come dining rooms, two sitting rooms, an office, two bathrooms and two toilets. Residents were provided with their own bedrooms. In line with the wishes of one resident, the inspector only viewed one residents bedroom. The inspector observed the room to be laid out and decorated in line with the resident's preference and wishes. There was a garden to the rear of the centre which contained two small buildings which were used for laundry and storage.

In summary, the inspector found that the provider and person in charge were endeavouring to ensure that each resident's well-being and welfare was maintained to a good standard and that there was a person-centred culture within the designated centre. The inspector found that there were a number of systems in place that were striving to ensure residents were safe and in receipt of good quality care and support. However, improvements were needed to ensure all systems in place were effective at all times. For example, in areas relating to staffing arrangement and fire precautions. Other improvements were needed in areas relating risk management, complaints procedures and safeguarding. These are discussed further in the next two sections of the report.

Capacity and capability

The purpose of this inspection was to monitor ongoing levels of compliance with the regulations and, to contribute to the decision-making process for the renewal of the centre's registration. 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 findings of this announced inspection were that residents were in receipt of a good quality and safe service, with good local governance and management supports in place. The provider and person in charge were endeavouring to ensure residents were supported to be as independent as they were capable of and were endeavouring to balance the resident's right to autonomy and liberty whilst at the same time ensuring their health and safety.

However improvements were needed to one of the staffing arrangements in place as it was negatively impacting on a resident. In addition, it was not in line with the information laid out in the centre's statement of purpose. Three complaints had been raised about the particular staffing arrangements since May 2024, with the latter complaint in November 2024 remaining open. Some improvements were also needed to the centres premises, risk management and safeguarding systems which are discussed further in the quality and safety section of the report.

The centre had a clearly defined management structure in place which was led by a capable person in charge. The person in charge was also responsible for two other designated centres. They were supported in their role by a person participating in management.

The person in charge was an experienced, qualified professional and demonstrated their knowledge of the residents' assessed needs. They were also aware of their legal remit to S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations).

The inspector found that governance systems in place were striving to ensure that service delivery was safe and effective through the ongoing auditing and monitoring of its performance resulting in a quality assurance system in place. The person in charge carried out a schedule of local audits throughout the year and followed up promptly on any actions arising from the audits. These audits assisted the person in charge ensure that the operational management and administration of centre resulted in safe and effective service delivery.

An annual review of the quality and safety of care between January 2023 and January 2024 had been completed, with the currently annual review of January 2024 – January 2025 at the final stages. In addition, two six-monthly unannounced visits to the centre had been carried out in June and again in December 2024. On completion of these audits, actions required where followed up by the person in

charge and progress relayed to the provider through person in charge and service manager quarterly meetings.

There were clear lines of accountability at individual, team and organisational level so that all staff working in the centre were aware of their responsibilities and who they were accountable to. There was a staff roster in place and it was maintained appropriately. There were two point five whole time equivalent staff vacancies in the centre. These vacancies were being covered by members of the current staff team as well as two agency staff who were familiar to residents.

The inspector reviewed a sample of staff files and found that they included all Schedule 2 requirements. The inspector spoke with two staff members during the inspection and found that they demonstrated appropriate understanding and knowledge of policies and procedures that ensured the safe and effective care of residents. Staff advocated on behalf of the residents. On the day of the inspection, the inspector observed kind, caring and respectful interactions between staff and residents.

The centre's statement of purpose included a staff allocation of five social care workers in the centre and noted that staff were always present to support residents when they were at home. However, a staffing arrangement, that involved one staff member supporting a discharged resident living in another designated centre was not acknowledged. The inspector was informed that since January 2024, on a daily basis, one staff member left the designated centre for up to five to six hours to support a person living in another residential centre (which was not part of this designated centre and which the person in charge was not responsible for). This arrangement meant that the provider could had not ensured that the number of staff employed in the centre was appropriate to the number and assessed needs of the current residents living in the centre or in line with the statement of purpose. This arrangement was also upsetting a resident living in the centre, with an open complaint ongoing.

Staff were required to complete training relevant to their role, and as part of their professional development. There was a training schedule in place for all staff working in the centre which was regularly reviewed by the person in charge. Overall, staff were provided with appropriate training. This ensured that staff were provided with the necessary skills and training to support them in the delivery of a quality, safe and effective service for each resident's assessed needs.

There was a schedule in place for staff one-to-one supervision meetings to support staff perform their duties to the best of their ability. A sample of a staff's supervision record was reviewed and observed to provide a space for shared learning, personal development and a review of training requirements.

Incidents were appropriately managed and reviewed as part of the continuous quality improvement to enable effective learning and reduce recurrence. There was appropriate information governance arrangements in place to ensure that the designated centre complied with all notification requirements.

Overall, the registered provider had established and implemented effective systems

to address and resolve issues raised by residents or their representatives. Systems were in place, including information on advocacy services, to ensure residents had access to information which would support and encourage them express any concerns they may have. However, improvements were needed to ensures that complaints received were responded to in a timely manner.

Registration Regulation 5: Application for registration or renewal of registration

The application for registration renewal and all required information was submitted to the Office of the Chief Inspector within the required time-frame. Where resubmission of floor plans were required, this has been addressed under Regulation 17.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge divided their role between this centre and two others. The local monitoring systems and structures in place supported this arrangement in ensuring effective governance, operational management and administration of the designated centres concerned. The person in charge was supported by the provider and person participating in management.

The inspector found that the 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.

Through speaking with the person in charge, the inspector found that they demonstrated sufficient knowledge of the legislation and their statutory responsibilities of their role.

The person in charge was familiar with the residents' needs and ensured that they were met in practice. The inspector found that the person in charge had a clear understanding and vision of the service to be provided and, supported by the provider, fostered a culture that promoted the individual and collective rights of the residents living in this centre.

There was evidence to demonstrate that the person charge was competent, with appropriate qualifications, skills and sufficient practice and management experience, to oversee the residential service and meet its stated purpose, aims and objectives.

Judgment: Compliant

Regulation 15: Staffing

At the time of inspection, the centre was operating with 2.5 WTE social care worker vacancies. The person in charge was endeavouring to ensure that there was continuity of staffing so that attachments were not disrupted and support and maintenance of relationships were promoted. On speaking with the person in charge and a review of the rosters, the inspector saw that the same two agency staff members had been employed in the centre for over fourteen months. On speaking with staff it was clear to see that a trusting relationship had been built with these agency staff and the two residents.

The inspector reviewed the staff rosters and found that it was maintained appropriately. For the most part, the designated centre's roster clearly identified the days and times that the staff worked in the centre. In addition the roster clearly demonstrated times the person in charge was working in the centre as well as the time they were working in the two other centres they were responsible for. However, the roster did not indicate times where staff were working in another designated centre. For example, where a roster noted a staff member worked in the centre 9am to 9pm it made no reference to when they left the centre during that shift to support a resident in another designated centre.

Not all residents or their representatives were happy with the above staffing arrangement. Three complaints had been made about the impact the arrangement was having on the support provided to a resident. For example, some of the complaint noted that the resident felt they were not getting adequate support from staff due to them leaving the centre to support another person. They were upset that the designated centre's car was being used to facilitate another person who does not live in the centre. The resident's upset was also noted in their newly developed positive behaviour support plan. Staff who spoke with the inspector noted how the resident's anxieties could increase when their staff member was not present in the house.

The inspector was informed the arrangement was also impacting on the trust built between staff and the resident and that relationships were starting to breakdown. For example, currently the resident was refusing to speak with two of the staff, which was noted to be partially due to this arrangement. .

The inspector found that the staff culture was endeavouring to promote and protect the rights, choices and dignity of residents through person-centred care and support, was been negatively impacted by this arrangement.

Judgment: Not compliant

Regulation 16: Training and staff development

One to one supervision meetings, that support staff in their role when providing care and support to residents, was being completed in line with the organisation's policy. Staff supervision one to one meetings were carried out three times a year with the person in charge. Staff who spoke with the inspector, advised that they found the meetings to be beneficial to their practice. Staff also relayed that they regularly received informal supervision with the person in charge when they were based in the centre.

There was a system in place to evaluate staff training needs and to ensure that adequate training levels were maintained.

From reviewing the training matrix for the staff team and specific staff training records of the staff team, the inspector found that staff were provided with training to ensure they had the necessary skills and knowledge to respond to the needs of the residents.

For example, staff had undertaken a number of training courses, some of which included the following:

- Emergency first aid
- Manual handling
- Fire safety
- Positive behaviour support
- Safe medication management
- Infection prevention and control including;
- safeguarding vulnerable adults.

Judgment: Compliant

Regulation 21: Records

On the day of the inspection, records required and requested were made available to the inspector. Overall, the records were appropriately maintained. The sample of records reviewed on inspection, overall, reflected practices in place.

On the day of the inspection, the person in charge organised for staff records to be made available to the inspector for review. On review of a sample of four staff files (records), the inspector found that they contained all the required information as per Schedule 2.

Judgment: Compliant

Regulation 22: Insurance

The registered provider had valid insurance cover for the centre, in line with the requirements of the regulation.

The service was adequately insured in the event of an accident or incident. The required documentation in relation to insurance was submitted as part of the application to renew the registration of the centre.

The inspector reviewed the insurance submitted to HIQA and found that it ensured that the building and all contents, including residents' property, were appropriately insured. In addition, the insurance in place also covered against risks in the centre, including injury to residents.

Judgment: Compliant

Regulation 23: Governance and management

The governance and management systems in place were found to operate to a good standard in this centre. Overall, there was a clearly defined management structure that identified the lines of authority and accountability and staff had specific roles and responsibilities in relation to the day-to-day running of the centre; The person in charge was supported by a person participating in management to carry out their role in this centre.

The provider had completed an annual report in January 2024 of the quality and safety of care and support in the designated centre and there was evidence to demonstrate that the residents and their families were consulted about the review. There were a number of actions to be addressed in 2024, many of which had been completed. A number of goals had been put in place for the year which included front and back garden maintenance, holidays for residents and fund raising for a new centre vehicle. The front garden was completed and holidays had been organised.

In addition to the annual review, there was a comprehensive local auditing system in place in the centre to evaluate and improve the provision of service and to achieve better outcomes for residents. A monthly data report was completed by the person in charge each month. The results of the report was brought to a management meeting between the person in charge and service manager to review issues arising and actions required. Some of the areas reviewed by the report included monitoring of residents' goal progress, quality and safety checks, money audits, safeguarding referrals, complaints and complements, fire drills, environmental risks but to mention a few.

Staff team meetings were taking place regularly and provided staff with an opportunity for reflection and shared learning. On review of the minutes of the last two meetings, the inspector saw that topics such as safeguarding, accidents and incidents, reporting e-forms, resident's positive behaviour support guideline, monthly

reports, first aid, health and safety issues, supervision, finance, updates on residents, household budget, risk assessments car clean, tracking residents' goals. key-working and maintenance issues were discussed at the meetings. Decisions were made and followed on by actions and time frames to be completed.

The inspector found that overall, governance and management systems in place in the centre were effective in ensuring good quality of care and support was provided to residents. However, improvements were needed to ensure that the provider had appropriate resources in place (in terms of staffing) and that these were in accordance with the designated centre's statement of purpose. Improvement were also needed to ensure that the provider's fire safety management systems in place, were effective at all times. Full details are addressed under regulation 15 and 28.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider had submitted a statement of purpose which for the most part, accurately outlined the service provided and met the requirements of the regulations.

The inspector reviewed the statement of purpose and found that it described the model of care and support delivered to residents in the service and the day-to-day operation of the designated centre. The statement of purpose was available to residents and their representatives.

In addition, a walk around of the designated centre confirmed that the statement of purpose, for the most part, accurately described the facilities available including room function.

The person in charge was aware of their legal remit to review and update the statement of purpose on an annual basis (or sooner) as required by S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations).

Matters relating to staffing and description of premises' rooms have been addressed under regulation 15, 17 and 23.

Judgment: Compliant

Regulation 31: Notification of incidents

There were effective information governance arrangements in place to ensure that

the designated centre complied with notification requirements.

The person in charge had ensured that all adverse incidents and accidents in the designated centre, required to be notified to the Chief Inspector of social services, had been notified and overall, within the required time frames as required by S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations).

The inspector found that incidents were managed and reviewed as part of the continuous quality improvement to enable effective learning and reduce recurrence. On review of team meeting minutes and through speaking with the person in charge, the inspector found that where there had been incidents of concern, the incident and learning from the incident, had been discussed at staff team meetings. For example, on review of staff team minutes in March 2024, the inspector saw that, where a notification had been submitting relating to a serious incident that required hospital treatment (NF03), new safety measures and medical referrals had been discussed and shared with staff at the meeting.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had established a complaints procedure which was underpinned by a comprehensive policy. The complaints procedure was available in an easy-to-read format and accessible to residents. A copy of the procedure alongside information on advocacy was located in a communal space in the centre. From speaking with the person in charge and staff, the inspector was informed that the complaints procedures were regularly discussed with residents to promote awareness and understanding of the procedures. Staff and management advocated for residents and supported them engage in the complaint process when required.

The person in charge was aware of all complaints and was endeavouring to ensure that they were followed up and resolved in a timely manner, where possible. However, on review of the complaints log the inspector saw that a similar complaint had been logged by a resident in May, August and again in November 2024. While the person in charge had attempted to resolved it locally, the resident had not been fully satisfied with measures put in place to try resolve the issue. The November complaint record noted that the resident was not satisfied with the response and the complaint remained open.

The person participating in management had engaged with the resident and escalated the complaint to the provider. The provider had contacted the resident to discuss the complaint however, a meeting date had yet to be confirmed from both sides.

Overall, the inspector found that the timeliness to resolve the complaint was not

appropriate and overall had resulted in negative impacts for the resident in relation to choice, rights and relationships with their staff members.

Judgment: Substantially compliant

Quality and safety

This section of the report details the quality and safety of the service for the residents who live in the designated centre.

The inspector found that the person in charge and staff were aware of residents' needs and knowledgeable in the person-centred care practices required to meet those needs. However, to ensure positive outcomes for residents at all times, improvements were needed to ensure the quality and safety of service delivery at all times. In particular, improvements were needed to the centre's fire safety management systems. In addition, some improvements were needed to premises, risk management and safeguarding.

The inspector found that the systems in place for the prevention and detection of fire required review. While there was fire safety equipment in place in the centre, it had not been serviced on an annual basis. The person in charge had ensured that local fire safety checks took place regularly and were recorded and that fire drills were taking place at suitable intervals. However, not all lone working staff had completed fire drills. In addition, improvements were needed to ensure timely responses to risks identified. This was to ensure that where residents may choose to have a build-up of items in their room, they were supported to do this in a way that was safe for them and other residents living in the centre.

For the most part, the design and layout of the premises of the designated centre were in line with the statement of purpose and met the needs of residents living in the centre. The house was observed to be clean and tidy and in good upkeep and repair. One resident was unhappy with the size of their room however, the person in charge was in discussion with the resident regarding possible on-site alternative accommodation. There were a small number of upkeep and repair works needed to some parts of the house and a review of the floor plans was required to ensure they accurately reflected the layout of two rooms.

The inspector reviewed residents' files and documentation that related to the care and support provided to them. They were found to contain comprehensive assessments of need and care plans. The person in charge had ensured that a review of assessment of need was completed for each resident on an annual basis and in consultation with each resident, and where appropriate included family and/or representatives and multi-disciplinary input. Where appropriate, there was an accessible version of the plan available to residents.

Overall, the inspector found that he provider and person in charge promoted a

positive approach in responding to behaviours that challenge. Residents were provided with positive behaviour supports plan and they were found to be up-to-date.

The inspector saw that, where restrictive procedure were being used, they were based on centre and national policies. Where applied, the restrictive practices were clearly documented and were subject to review by the appropriate professionals involved in the assessment and interventions with the individual. The person in charge was ensuring that practices in place were the least restrictive for the shortest duration necessary.

The provider had ensured that the risk management policy met the requirements as set out in the regulations. There were systems in place to manage and mitigate risks and keep residents and staff members safe in the centre. Individual and location risk assessments were in place to ensure the safe care and support provided to residents. However, a number of risks were identified on the day by the inspector that required a risk assessment that included measures to reduce the risk. In addition, not all measures within risk a assessment were in place, which overall, impacted on the effectiveness of the assessment and the safety of the resident.

For the most part, residents living in the designated centre were protected by appropriate safeguarding arrangements. Staff were provided with suitable training relating to keeping residents safeguarded. The person in charge and staff demonstrated good levels of understanding of the need to ensure each resident's safety. There was an appropriate level of oversight to ensure that safeguarding arrangements ensured residents' safety and welfare. However, some improvements were needed to ensure that where there were safeguarding measures in place to protect residents, that they were clearly documented for all staff to follow.

There were effective infection, prevention and control (IPC), measures and arrangements to protect residents from the risk of infection. From a review of documentation, from observations in the centre and from speaking with staff, the inspector found that the infection, prevention and control measures were effective and efficiently managed to ensure the safety of residents.

Regulation 12: Personal possessions

The inspector found that there were systems in place to ensure that each residents' personal possessions were respected and protected; Where appropriate and in line with residents wishes, they were provided with an inventory of their personal possessions and this was included in their personal plan.

During the walk around of the centre, the inspector was given permission by one resident to view their bedroom. The inspector observed that bedroom was equipped with sufficient and appropriate storage for the resident's personal belongings. For example, there was an adequate amount of wardrobe space provided for the

resident's clothes and belongs.

The inspector was informed that a resident had recently purchased an armchair for their bedroom to support better enjoyment while playing their game console.

There were laundry facilities available to residents if they wished to avail of them, including a washing machine and dryer. Where a resident chose to complete their own laundry without any assistance, this choice was respected.

In line with residents' support needs, records of all residents' monies spent were transparently kept in line with best practice and the provider's policy on managing residents' finances.

All residents living in the centre had access to a bank account and an associated bank card.

There were a number of oversight mechanisms to ensure residents monies were safeguarding and this was through nightly and monthly checks by staff and the person in charge.

Judgment: Compliant

Regulation 17: Premises

The physical environment of the house was clean and in good decorative and structural repair. The design and layout of the premises ensured that each resident could enjoy living in a comfortable and homely environment. This enabled the promotion of independence, recreation and leisure and overall enabled a good quality of life for the residents living in the designated centre.

During the walk around of the centre, the inspector only observed one of the two residents' bedrooms and found it to be personal to the resident and relayed their likes an interests. The room included family photographs, a television and gaming console, plenty of shelving and storage room.

One of the residents was not happy about the size of their bedroom and had noted this in their HIQA survey but had also spoke to the person in charge about it. The inspector was informed that planning permission had been submitted to the local counsel to build a self-contained apartment out the back of the house. The person in charge had met with the resident on a number occasions to discuss the possibility of this alternative accommodation (pending planning permission and funding). The person in charge told the inspector that this type of accommodation would better promote the resident's independence and provide them with more space.

A recent infection, prevention and control audit had identified a number of upkeep and repair maintenance works needed in the premises. Some had been completed and some, such as the requirement for new carpet on one set of stairs, was due the

day after the inspection. However, further work was needed, some of which had not been identified in the audit. For example;

- A carbon monoxide alarm had been replaced by a new alarm however, the old alarm had not been removed and the cover remained on the kitchen sealing and was exposing dusty and cobwebbed wires.
- The provider had installed thumb locks in all bedroom doors however, the old break glass boxes or frames of boxes had not been removed from the wall beside the door.
- A hold in an upstairs wall had been filled but not satisfactorily plastered or painted over, leaving cracked surround of the hole and overall impacting on infection prevention control measures (in terms of cleaning).
- Four radiators in the house were observed to have a lot of rust on them. The small radiator in the laundry room had been identified in the provider's IPC audit however, an appropriate and timely plan was not in place to respond to the risk it posed.
- The small shed out the back of the premises was observed to have a lot of cobwebs on internal walls, ceiling and over light switches and plugholes.

A review, update and resubmission of the designated centre's floor plan for the premises was needed. An application to vary was completed in February 2024 that saw a sitting room change to a bedroom/living room. This was in an effort to better support the changing needs of a resident. However, on walking around the centre, the room was laid out and only being used as living room. The inspector was informed that the resident who used the room had since been discharged. In addition, an upstairs room, which was once a bedroom, was noted on the floor plans as a multi-purpose room. The inspector observed that the room was currently being used as a storage room with no obvious multi-purpose function.

Judgment: Substantially compliant

Regulation 20: Information for residents

The registered provider had prepared a guide for residents which met the requirements of regulation 20. For example, on review of the guide, the inspector saw that information in the residents' guide aligned with the requirements of associated regulations, specifically the statement of purpose, residents' rights, communication, visits, admissions and contract for the provision of services, and the complaints procedure.

The guide was written in easy to read language and was available to everyone in the designated centre.

Judgment: Compliant

Regulation 26: Risk management procedures

The inspector reviewed the centre's risk management policy and found that the provider had ensured that the policy met the requirements as set out in the regulations. The policy had been reviewed in June 2023.

For the most part, where there were identified risks in the centre, the person in charge ensured appropriate control measures were in place to reduce or mitigate any potential risks. The person in charge had completed a range of risk assessments with appropriate control measures, that were specific to residents' individual health, safety and personal support needs.

However, on the day of the inspection, the inspector found that not all risks had been identified. In addition, where risks had been identified, not all measures to mitigate or reduce the risk (that were included in the assessment), were in place.

For example, a resident's risk assessment for potentially poor medication practice included measures such as, weekly medication audits to be completed with the resident, staff assist resident to sign medicine administration sheet (MAS) every time medicine is administered, however, theses measure were not being carried out.

On speaking with the person in charge and staff, the inspector was informed that one of the residents was unlikely to express if they had a concern or were upset by something a person did or said to them. However, this had not been identified as risk and as such there was no measures in place to mitigate the risk. (This is also addressed under regulation 8).

An environmental audit in January 2024 and a visual observation by a staff member in April 2024, observed a lot of clutter, and possible combustible materials, in a resident's bedroom. The inspector was informed that the resident did not allow management or staff enter their bedroom. The person in charge was engaging with the housing association regarding the tenancy agreement in an attempt to find a resolution to provide better oversight of the room. However, in the interim, no risk assessment or measures to reduce or mitigate any possible fire risk, had been put in place.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The inspector found that, for the most part, the infection prevention and control measures were effective and efficiently managed to ensure the safety of residents.

The centre was observed to be clean and cleaning records demonstrated a

satisfactory level of adherence to cleaning schedules.

There were flushing checks in place two showers in the house that were not in regular use. The inspector saw that staff were adhering to the checks.

The inspector observed appropriate cleaning equipment and cleaning products and saw that they were stored appropriately.

The provider had ensured there were appropriate oversight mechanisms in place to review the effectiveness of the infection prevention and control measures in place. An infection prevention and control audit had taken place in the centre in 2024 and for the most part, demonstrated the effectiveness of the measures in place to protect residents. In addition, health and safety check list (November 2024), six monthly unannounced, staff meetings and monthly data reports all included infection prevention and control matters within them.

The inspector reviewed training schedules that demonstrated that, staff had completed specific training in relation to infection, prevention and control and overall, refresher training was up-to-date.

Matter relating to a small number of required upkeep and repairs are address under regulation 17 (Premises).

Judgment: Compliant

Regulation 28: Fire precautions

The provider and person in charge were endeavouring to make sure that there were effective fire safety management systems were in place to ensure the safety of the residents.

The provider and person in charge had ensured that daily, monthly and quarterly fire checks of the precautions in place were completed to ensure their effectiveness in keeping residents safe in the event of a fire. All staff had completed appropriate fire safety training.

However, a number of improvements were needed to ensure the safety of residents at all times.

Regular fire drills were taking place in the centre to provide assurances that residents could be safely and promptly evacuated and to ensure the effectiveness of the fire evacuation plans. For example, fire safety documentation demonstrated that a day time drill had taken place in January 2024 and a night-time drill in August 2024. Subsequent to the inspection, the person in charged submitted an email noting that one of the two regular agency staff had completed a fire-drill the evening of the inspection. However, further action was needed to ensure all staff had completed both a day and night time drill and in particular, where staff carry

out lone working sleepover shifts.

On the day of the inspection, the inspector observed that fire extinguisher were due an annual service on 19th of January 2025. In addition, the label on the fire extinguisher in the external laundry room was dated June 2023. Subsequent the inspection, two documents signed by a technician were submitted, the documents adequately provided sufficient assurances. Overall, this meant that the provider's systems in place, for ensuring all fire equipment was appropriately maintained, was not effective.

The designated centre's fire safety feedback report October 2024, noted a clear out of clutter and possible combustible items in a resident's room was proving problematic. A environmental safety checklist for falls prevention in January 2024 noted that a resident's bedroom was not easily accessible and that there was a huge amount of clutter present. An observation from a staff member in April 2024, noted a concern regarding the build-up of clutter in the same resident's bedroom. While the person in charge had been mindful of a recent bereavement as well as the privacy preferences of the resident when responding to the risk, overall, the timeliness of response was posing a risk to the safety of the resident sleeping in the room, as well as the other resident and staff. A plan and appropriate time line, to address the risk, was required.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that residents' health, personal and social care needs had been assessed. The assessments reflected the relevant multidisciplinary team input, and informed the development of care plans which outlined the associated supports and interventions residents required.

The inspector reviewed the two residents' personal plans and overall, found that the plans demonstrated that each resident was facilitated to exercise choice across a range of daily activities. Personal plans were regularly reviewed and residents, and where appropriate, their family members, were consulted in the planning and review process of their personal plans.

For example, the inspector saw in one resident's personal plan that their epilepsy support plan, general health support plan, falls support plan was updated in January 2025. Another plan demonstrated that residents were supported to attend annual review of their plan, with one resident's 'my life meeting' taken plan in March 2024 and next due in March 2025.

As part of the monthly data report, an audit of documentation within the personal plans, as well as goals progressed was completed. This was to ensure information within them was relevant and up-to-date.

Residents were provided with an accessible format of their personal plan in a communication format that they understood and preferred. There were easy to read "this is my all about me" section within the residents' plans. Photographs and picture formats of activities residents had taken part in within their plan.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were arrangements in place to provide positive behaviour support to residents with an assessed need in this area.

The inspector reviewed two positive behaviour support plans and found them to be detailed, developed by an appropriately qualified person and reviewed within the past year. One resident's plan had been reviewed and updated in February 2024 and another in January 2025. The plans contained proactive and reactive strategies to support residents in managing their behaviour in addition to a detailed outline the supports needed with personal activities, the resident's preferences and the behaviours displayed. In addition, clearly documented de-escalation strategies were incorporated as part of each residents' behaviour support planning with accompanying well-being and mental health support plans.

Staff had up-to-date knowledge and skills to respond to behaviour that is challenging and to support residents to manage their behaviour. The person in charge had ensured that staff had received training in positive behaviour supports and received regular refresher training in line with best practice.

The inspector saw there where restrictive procedure were being used, they were based on centre and national policies. Where applied, the restrictive practices were clearly documented and were subject to review by the appropriate professionals involved in the assessment and interventions with the individual.

The person in charge was endeavouring to ensure that the least restrictive practice for the shortest duration was implemented. For example, restrictions of a door sensor and locked cupboard, were both removed after a three month review when it was demonstrated that the risk had reduced. Where the risk arose again, the restriction was reapplied however, a review was planned for three months' time to see if it could be reduced or removed.

Judgment: Compliant

Regulation 8: Protection

For the most part, there were systems were in place to safeguard residents in their

home.

Where safeguarding incidents had occurred in the centre, the person in charge had followed up appropriately and ensured that they were reviewed, screened, and reported in accordance with national policy and regulatory requirements.

The inspector also noted the following:

· safeguarding and incidents were discussed at staff meetings.

· The training matrix demonstrated that all staff had been provided training in safeguarding of vulnerable adults and all was up-to-date.

· from reviewing four staff files with regard to schedule 2 of the regulations, all four staff had appropriate vetting in place.

There was an up-to-date safeguarding policy in the centre and it was made available for staff to review.

However, some improvements were needed to ensure all systems were effective. For example;

Where there had been a safeguarding incident between two residents, an interim plan had been put in place. Actions within the plan included consistent and familiar staff in place to support residents and a level of staff supervision of residents when they were in the same room. The person in charge had ensured that these actions were in place. The safeguarding concern had been closed by the national safeguarding team. However, the inspector found that there was no satisfactory risk assessment or guidelines in place relating to the supervision of residents when they were in a room together. This meant that, where new or unfamiliar staff were employed, they were not provided with adequate guidelines to enable the support residents in a safe way. As such, there was a potential risk of further safeguarding incidents occurring.

One of the residents had been provided training in safeguarding and from speaking with staff it was clear that the resident knew what safeguarding meant and knew how to raise any concern or complaint they may have. However, this was not the same for another resident. While staff told the inspector that they would be able to identify if the resident was upset through a number of behaviours, they said that the resident was unlikely to express or tell staff if they had a concern, were hurt or upset. As such, improvements were needed to ensure that the resident was empowered and assisted to develop the knowledge, self-awareness and understanding and skills needed for self-care and protection.

Judgment: Substantially 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 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Royal Oak OSV-0002361

Inspection ID: MON-0037183

Date of inspection: 28/01/2025

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • HSE National Recruitment Drive currently in action. • The roster for the designated centre now clearly indicates where staff are located throughout the day to support residents • The Director of Adult service is in communication with the Director of Nursing and the Director of Access, Integration & Adult Clinical Services (Chair of SMH Residential Approvals committee) to agree future staffing arrangements for the resident residing in another designated center • Staff continue to communicate with residents residing in the designated centre regarding staffing arrangements and any updates regarding this • The residents of this designated centre are communicated with by the person in charge and staff regarding their social and support needs, which are then reflected in staffing arrangements for the centre to facilitate supporting the residents. This is captured in resident contact sheets by the person in charge and in daily reports by staff • The designated Centre is registered for 3 residents. Currently 2 residents live in the designated centre. A vacancy remains.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • HSE National Recruitment Drive currently in action • The roster for the designated centre now clearly indicates where staff are located throughout the day to support residents • The Director of Adult service is in communication with the Director of Nursing and the	

Director of Access, Integration & Adult Clinical Services (Chair of SMH Residential Approvals committee) to agree future staffing arrangements for the resident residing in another designated center
• Staff continue to communicate with residents residing in the designated centre regarding staffing arrangements and any updates regarding this. This is captured in resident contact sheets by the person in charge and in daily reports by staff
• The designated centres statement of purpose has been updated to reflect staffing arrangements in the centre, to include supporting a resident residing in another designated centre as well as service users residing in this designated centre. Completed on 13.02.2025
• Fire extinguishers have been serviced as per policy on 29.01.2025
• Regular agency staff have completed night fire drill due to lone working on 28.01.2025
• Communication from our external contractor re fire extinguisher states that +/- 30 days servicing intervals as per I.S. 291. As such the extinguishers were still within the servicing timelines. The one fire extinguisher in the laundry room which label stated the last service was January 2023 was serviced on the 29.01.2025 to be in line with servicing requirements. This was flagged with the contractor also.
• For permanent and regular staff on the designated centres roster, all staff complete in rotation a simulated role play annually. This simulates completing a night-time evacuation putting together the fire procedure. Each simulation is timed and debrief provided following completion. Any staff that miss the training complete the alarmed fire drills to counterbalance missing this exercise.
• To ensure fire safety regulations are complied with for unfamiliar staff on duty, a handover by permanent and regular staff provides a run through of the evacuation procedure and support requirements of service users. Completion of regular alarmed drills to account for every time an unfamiliar staff is covering a night-time shift is likely to result in desensitisation of the alarm noise by service users and possible non response. As such the handover is the most effective means of providing the information required and letting service users know there is no planned fire drill that night to ensure they get up and leave ASAP.
• An ICM was held on the 06.02.2025 to review supports available to the resident to address clutter in their bedroom and refusing staff access and supports with this
• A letter was sent by the organisations housing department on the 13/02/2025 to the resident advising that they would be on site to review the premises, to include the resident's bedroom on the 26/02/2025
• A member of the housing department and the organisations fire officer viewed the premises to include the residents bedroom on the 26/02/2025. The resident was in attendance and supported by the person in charge.
• An ICM will be held on the 05/03/2025 to review the findings and devise an action plan which will be communicated with the resident also
• The risk assessment pertaining to fire safety for the resident has been updated to reflect current risks and has been reviewed by the organisations fire office and clinical psychologist.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The resident has been communicated with regularly by the service manager and has advised they are satisfied for the service manager to be their point of contact at present for information update pertaining to staffing in the centre.
• The resident will be kept informed of all updates concerning this in line with policy
• HSE National Recruitment Drive currently in action
• The roster for the designated centre now clearly indicates where staff are located throughout the day to support residents
• The Director of Adult service is in communication with the Director of Nursing and the Director of Access, Integration & Adult Clinical Services (Chair of SMH Residential Approvals committee) to agree future staffing arrangements for the resident residing in another designated center
• The residents of this designated centre are communicated with by the person in charge and staff regarding their social and support needs, which are then reflected in staffing arrangements for the centre to facilitate supporting the residents. This is captured in resident contact sheets by the person in charge and in daily reports by staff

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• A carbon monoxide alarm had been replaced by a new alarm however, the old alarm had not been removed and the cover remained on the kitchen sealing and was exposing dusty and cobwebbed wires. This action was completed on the 20/02/2025 by technical service department
• The provider had installed thumb locks in all bedroom doors however, the old break glass boxes or frames of boxes had not been removed from the wall beside the door. This action was completed on the 20/02/2025 by technical service department
• A hole in an upstairs wall had been filled but not satisfactorily plastered or painted over, leaving cracked surround of the hole and overall impacting on infection prevention control measures (in terms of cleaning). This was filled on the 20/02/2025 by technical service department
• Four radiators in the house were observed to have a lot of rust on them. The small radiator in the laundry room had been identified in the provider's IPC audit however, an appropriate and timely plan was not in place to respond to the risk it posed. This has been logged with the technical service department and housing and will be completed by 31/08/2025
• The small shed out the back of the premises was observed to have a lot of cobwebs on internal walls, ceiling and over light switches and plugholes. This action was completed on the 20/02/2025 by technical service department
• New carpet was laid on the stairs of one side of the designated centre on the 29/01/2025

• A review of the designated floor plans were submitted on the 13.02.2025
• Items stored in the previously named multipurpose room belonging to a resident in another designated centre are now moved to the resident in the other designated centre
• Planning permission to build a self-contained apartment in the back garden to support one residents needs remains ongoing with Fingal County Council

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The risk assessment in place for one resident independently taking their medication has been reviewed in consultation with the organisations medical and health trainer, person in charge and the resident - Complete 20.02.2025
• The resident is willing to trial changing medication dispense to blister pack form. Paperwork in consultation with the resident and the organisations medical management team ongoing to commence this
• The resident has agreed for the person in charge to collect his prescribed medications from the pharmacy with him on the 02.03.2025
• The resident is now engaging with staff more to advise of the self management of their medications and a recording sheet will be devised in consultation with the person in charge and the resident to record self administration of medications. This will be put in place for recording and auditing of medications following the above point.
• An ICM was held on the 06.02.2025 to review supports available to the resident to address clutter in their bedroom and refusing staff access and supports with this
• A letter was sent by the organisations housing department on the 13/02/2025 to the resident advising that they would be on site to review the premises, to include the resident's bedroom on the 26/02/2025
• A member of the housing department and the organisations fire officer viewed the premises to include the residents bedroom on the 26/02/2025. The resident was in attendance and supported by the person in charge.
• An ICM will be held on the 05/03/2025 to review the findings and devise an action plan which will be communicated with the resident also
• The risk assessment pertaining to fire safety for the resident has been updated to reflect current risks and has been reviewed by the organisations fire office and clinical psychologist.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Fire extinguishers have been serviced as per policy on 29.01.2025
• Regular agency staff has completed a night fire drill due to lone working on 28.01.2025
• Communication from our external contractor re fire extinguisher states that +/- 30 days servicing intervals as per I.S. 291. As such the extinguishers were still within the servicing timelines. The one fire extinguisher in the laundry room which label stated the last service was January 2023 was serviced on the 29.01.2025 to be in line with servicing requirements. This was flagged with the contractor also.
• For permanent and regular staff on the designated centres roster, all staff complete in rotation a simulated role play annually. This simulates completing a night-time evacuation putting together the fire procedure. Each simulation is timed and debrief provided following completion. Any staff that miss the training complete the alarmed fire drills to counterbalance missing this exercise.
• To ensure fire safety regulations are complied with for unfamiliar staff on duty, a handover by permanent and regular staff provides a run through of the evacuation procedure and support requirements of service users. Completion of regular alarmed drills to account for every time an unfamiliar staff is covering a night-time shift is likely to result in desensitisation of the alarm noise by service users and possible non response. As such the handover is the most effective means of providing the information required and letting service users know there is no planned fire drill that night to ensure they get up and leave ASAP.
• An ICM was held on the 06.02.2025 to review supports available to the resident to address clutter in their bedroom and refusing staff access and supports with this
• A letter was sent by the organisations housing department on the 13/02/2025 to the resident advising that they would be on site to review the premises, to include the resident's bedroom on the 26/02/2025
• A member of the housing department and the organisations fire officer viewed the premises to include the residents bedroom on the 26/02/2025. The resident was in attendance and supported by the person in charge.
• An ICM will be held on the 05/03/2025 to review the findings and devise an action plan which will be communicated with the resident also
• The risk assessment pertaining to fire safety for the resident has been updated to reflect current risks and has been reviewed by the organisations fire office and clinical psychologist.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• A safeguarding risk assessment is in place which will be handed over to any new staff – This is on the centres induction checklist also
• Support care plans for both residents have been updated on the 29.01.2025 to highlight staff observations of both residents when together due to safeguarding risks in past
• The organisations clinical psychologist assisted the person in charge, the team and the

resident to improve the residents understanding, empowering and self awareness of protection

• Easy read support material is now in place to support the resident. The residents keyworker will meet with resident once a week to review these easy read materials pertaining to protection

• In 6 months, following a review and education of the easy read materials, the resident will be offered to watch some of the organisations safeguarding videos, developed with services users throughout the organisations input. This will be a method of understanding the resident's knowledge of protection following the above educative and supportive piece.

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.	Not Compliant	Orange	30/06/2025
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	03/03/2025
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet	Substantially Compliant	Yellow	31/08/2025

	the aims and objectives of the service and the number and needs of residents.			
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	31/08/2025
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	03/03/2025
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	30/06/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the	Substantially Compliant	Yellow	30/04/2025

	assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	30/04/2025
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	03/03/2025
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	03/03/2025
Regulation 28(3)(b)	The registered provider shall make adequate arrangements for giving warning of fires.	Substantially Compliant	Yellow	03/03/2025
Regulation 34(3)(a)	The registered provider shall nominate a person, other than the person nominated in paragraph 2(a), to be available to residents to ensure that: all complaints are appropriately responded to.	Substantially Compliant	Yellow	03/03/2025
Regulation 08(1)	The registered provider shall	Substantially Compliant	Yellow	31/08/2025

	ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/08/2025