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:	Birchwood
Name of provider:	Health Service Executive
Address of centre:	Wexford
Type of inspection:	Unannounced
Date of inspection:	15 January 2020
Centre ID:	OSV-0006452
Fieldwork ID:	MON-0027085

About the designated centre

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

Birchwood is a dormer bungalow located in a rural setting. It is within walking distance of the local village. This village provides amenities such as shops, takeaways and restaurants. The statement of purpose sets out that the centre has three bedrooms, a kitchen-dining room, living room and a rear garden. All three bedrooms have en-suites. This house is home to three residents and the capacity is three. Admissions are in accordance with the procedures for Wexford Residential Intellectual Disability Services. Admission is available to both male and female adults, with a severe to profound intellectual disability. Additional needs that are catered for include support with behaviours of concern, mobility issues and high dependency needs. Nursing care is available within the house at all times and nurses are the primary care provider. Residents have access to a range of allied health professions. The statement of purpose describes the objective of the centre as to "ensure the residents receive the best quality of care in accordance with regulations and standards. In pursuit of this, we will provide a living environment that promotes, maintains and develops resident's independence and wellbeing".

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 15 January 2020	11:25hrs to 17:00hrs	Carol Maricle	Lead

What residents told us and what inspectors observed

The inspector met with the three residents. The residents did not communicate verbally with the inspector therefore the inspector spent time with the residents by sitting alongside them and observing them as they went along their day interacting with each other and with staff.

The residents were observed dining, relaxing and leaving the centre to go out for lunch and do shopping.

The residents appeared very comfortable and content. They liked to sit in the kitchen with staff and also liked to rest in the living room. Some of the residents in particular enjoyed regular walks in the nearby village. Two residents were observed going out for lunch. A resident was observed leaving their home with a staff member to do the weekly grocery shop.

The residents were observed communicating with staff in their own unique style using body language, utterances and facial expressions. The inspector observed that the residents were spoken with by staff in an age-appropriate and warm manner. The staff were observed being patient and respecting the choices that residents made, especially around meal-times.

Overall, the residents appeared very content and relaxed. In discussions with the inspector, staff knew the residents very well and they could articulate how each resident liked to live their life. They could understand most of what each resident was communicating to them.

Capacity and capability

This was an unannounced inspection carried out following the opening of the centre in June 2019.

Overall, the residents living at this centre experienced a good life at the centre and there were some good examples of leadership, governance and management in aspects of the day-to-day running of their home. Notwithstanding these positive findings, there were significant areas identified throughout the inspection that were not in compliance with the Regulations and this meant that there was inconsistency in the governance arrangements. These areas are highlighted in this report.

During the course of this inspection, the inspector viewed evidence of a clear

management system in place. The person in charge managed two centres and in her absence she was supported by a clinical nurse manager who worked full-time at this centre. The person in charge was suitably qualified and experienced. She was knowledgeable of the relevant regulations and standards relevant to her role. On the day of the inspection, the person in charge along with a senior nurse demonstrated a good knowledge of the resident's needs and good oversight of aspects of the day-to-day running of the centre. A number of other persons were appointed to manage the centre, two of whom were met with by the inspector. They were also very familiar with the needs of the individual residents.

Although all of those involved in the management team were aware of the needs of the residents, they at times did not possess the necessary information on other aspects of the centre such as the terms and conditions of their leasing agreement with the property landlord. This had an impact on the residents in the following ways; they did not have access to a rear garden (although they did have access to a large paved area). There was confusion around the permissions required in installing fixtures in the home which meant that some residents had pictures and artwork displayed in their bedroom while others did not. The standard of paintwork across the entire centre was of a particularly poor standard thus impacting the homeliness of the centre and it was unclear whose responsibility it was to address this.
The house had concrete blocks stacked outside the front of the property and the person in charge did not know the plan for these building materials. An assessment of a large amount of furniture located across the first floor and whether or not it posed as a fire hazard had not been conducted. Residents did not all have the correct amount of storage for their personal items, as evidenced by one not having a locker and another using containers for some of their clothing rather than a chest of drawers. It was identified in internal audits carried out at the centre that the residents had been without blinds and curtains in their home for some time prior to this inspection although this was rectified prior to this inspection in most of the rooms. Following this inspection, clarification was provided by the provider on most of these matters and action taken by the registered provider regarding fire safety.

In accordance with the Regulations the provider is required to carry out unannounced visits to the designated centre every six months to review the quality and safety of care and support that is provided to residents. As this centre has only opened in June 2019 this visit had not taken place and a person involved in the day to day management of the centre provided the inspector with a date for this visit. An annual review of the centre was also not conducted however the centre was not yet open 12 months. In accordance with oversight procedures, a manager within the organisation had visited the centre in the six months since its opening however these reports could not be retrieved for the inspector on the day of the inspection. These reports were forwarded following the inspection and showed a level of oversight at the centre however none of the reports carried a summary of findings, actions, timelines and persons responsible to address the findings.

The provider had ensured that there were sufficient resources in place for the running of the centre. Residents had the use of vehicles to promote their day to day living and being out in the community. There were multidisciplinary services available to all residents from both the provider and the health service executive and

residents were supported to attend same. There were policies in place to guide staff in their care of the residents and almost all had been updated within the three years of the date of this inspection. The residents were supported and cared for by staff who were observed as being highly attentive to their needs. Staff members spoken with by inspectors demonstrated a very good knowledge of residents' needs and the supports they required. It was clear that the residents had formed positive bonds with members of the staff team and they made their needs known through their facial expressions, utterances and bodily gestures. The inspectors viewed evidence of appropriate staffing arrangements to support residents however the person in charge did not have full oversight of the qualifications, training and vetting of agency staff employed at the centre.

The inspector saw some evidence that the provider used, collected and evaluated information. There was trending of incidents and accidents at the centre by the wider management team in addition to the person in charge. A complaints system was in place within the wider organisation and to date there had been one complaint received and resolved. Where safeguarding concerns were made these had been processed in line with statutory guidance.

There was a directory of residents in place. This contained the required information, as per the Regulations for the current residents. It did not however include the information regarding four residents that had been admitted to and discharged from this centre following the opening of the centre in 2019.

The statement of purpose had not been resubmitted to HIQA following works carried out both inside and outside the centre. This was submitted immediately following this inspection.

Regulation 14: Persons in charge

The registered provider had appointed a person in charge who was qualified and experienced. She had responsibilities for two centres, including this centre.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had ensured that the number, qualification and skill mix of the staff was appropriate to the needs of the residents. There was an actual and a planned rota. However, the person in charge had not ensured that they had obtained in respect of all staff the information and documents specified in Schedule 2.

Judgment: Not compliant

Regulation 16: Training and staff development

The person in charge had not ensured that all staff had the required training as per the organisation's training schedule however where there were gaps most training dates were identified.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The registered provider had established a directory of residents however this did not include the admission and discharge of four residents that had lived at the centre for a short period of time following the opening of the centre. The directory did contain the details of the current residents.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had ensured that there was a clearly defined management structure in the centre. There were systems in place to ensure that an unannounced visit to the centre would be conducted every six months and an annual report prepared. The registered provider had not ensured that there were systems in place to ensure that the service was effectively monitored, as evidenced by the lack of clear findings and action plans following internal visits to the centre by the management team.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had not ensured that the statement of purpose had been forwarded to HIQA following reconfiguration of the interior and exterior of the premises. It was however forwarded to HIQA shortly following this inspection. The revised statement did not sufficiently set out the design and layout of the centre to ensure that the reader could differentiate clearly between the layout of the centre and the remaining areas which were not part of the designated centre. The statement did not include reference to the conditions of registration.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge had given notice to HIQA in writing of all relevant incidents.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had ensured that there was a complaints procedure in place. One complaint had been received since the opening of the centre. This was submitted by staff on behalf of a resident and was resolved.

Judgment: Compliant

Quality and safety

This centre had opened in 2019 and provided at first a residential service to four residents whom had since discharged from the service. At the time of this inspection, there were three residents living in this home. The inspector reviewed the quality and safety of the service and found that residents were kept safe and cared for by staff to a good standard. There was a good focus on the residents. However, significant improvements were identified in a number of areas, including fire safety.

This inspection found that the staff team focused on the needs of the residents. The staff team were very knowledgeable about how to keep each resident comfortable,

content and stimulated. There was evidence that residents were supported to attend day services and the staff team were now starting to receive better information on the programme of events that residents participated in when they attended day services. This meant that the team had better information and could thus plan more carefully activities for residents to enjoy when at home. In conversation with staff and the management team, it was clear that in their move to their new home each resident was exposed now to more opportunities for learning and growth and achievements had been made by them, such as their enhanced involvement in the running of their home. There was, however, a lack of written documentation that showed these positive developments.

The inspector observed meals being prepared and there was a pleasant smell of cooked food in the kitchen. The inspector observed a resident being supported to eat and drink by a staff member who was showing a high level of sensitivity to their needs.

There was evidence to show that residents were supported in their health. An annual assessment of the health of each resident was conducted. Each resident was supported to attend healthcare appointments. There was written evidence to show that the health of the residents had improved since their admission to their new home. However, the inspector found that a resident had been awaiting a staff member to discuss on their behalf with their general practitioner an aspect of their healthcare that might enhance their quality of life and this conversation had not been carried out to date.

During this inspection, the inspector viewed a sample of personal planning arrangements and found that there was no annual review of the personal planning arrangements of the three residents in 2019. This was concerning given that the residents had moved home during this time. The person in charge acknowledged this gap and set out plans to the inspector to address this matter. The lack of a formal personal plan review meant that there was no discussion and agreed actions or goals with the resident in conjunction with their family and/or advocates on their personal planning arrangements.

There was a positive culture evident in this home around the use of restrictive practices. The rights of the residents to walk freely around their home was an area that that the person in charge had closely attended to since the residents had moved to their new home. There were some improvements required in the documentation to support this positive culture.

The residents were kept safe while living at this centre. The staff team were trained in adult safeguarding. Staff were knowledgeable of the reporting pathways for safeguarding concerns and there was evidence that concerns were reported on appropriately. Staff reported that the residents were compatible and got along well with each other. There were systems in place to manage risk. Each resident had individualised risk assessments developed prior to their admission to the centre and thereafter.

As set out already in this report, the registered provider had not ensured that the

premises was kept in a good state of repair externally and internally. There was a significant amount of waste construction material outside the bedroom of a resident and no written plan in place to address same. The first floor of the premise was undergoing construction work and the management team did not have information on these plans. A stairs lobby was only partially finished with large gaps in walls evident. There was a centre risk register in place but it did not contain reference to the hazards identified by this inspector as commented upon in this report.

The inspector reviewed the arrangements in place for fire safety. The residents had participated in fire drills. The staff team had received training in 2019 in fire safety. The emergency firefighting equipment had been serviced on an annual basis. There was an alarm panel in place. Despite these positive findings, the inspector found two cylinders of oxygen not stored appropriately. The emergency lighting had not been tested in regular quarterly intervals. The provider could not assure the inspector that the storage of items in the first floor did not represent a fire hazard. A fire officer report submitted to HIQA following this inspection set out a number of recommendations to upgrade fire safety arrangements in the first floor.

Regulation 13: General welfare and development

The registered provider provided each resident with access to facilities and recreation. While there were some opportunities for residents to participate in activities in their local area and at a day service their participation in same was not linked to their assessed strengths and capabilities. There were no records supporting the skills training that each resident was participating in since their move to the centre, such as independence skills training.

Judgment: Substantially compliant

Regulation 17: Premises

The provider did not ensure that the centre was kept in a good state of repair externally and internally. Some rooms of the centre were not suitably decorated as the painting was not finished to a high standard. There was building materials located outside of the centre and the management team did not know the plan for same.

Judgment: Not compliant

Regulation 18: Food and nutrition

The person in charge had ensured that residents were provided with food and drink that was prepared and cooked in their home and was consistent with their dietary needs and preferences. Residents were assisted with eating and drinking.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had ensured that risks relevant to each resident were identified and assessed. The person in charge maintained a centre risk register however some of the calculations of risk required review. The inspector identified some hazards at the centre that had not been risk assessed.

Judgment: Not compliant

Regulation 28: Fire precautions

The emergency lighting had not been tested in regular quarterly intervals. The provider could not assure the inspector that the storage of items in the first floor did not represent a fire hazard. A fire officer report submitted to HIQA following this inspection set out a number of recommendations to upgrade fire safety arrangements in the first floor.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Each resident did have a personal plan however the person in charge had not ensured that these plans had been reviewed in line with the Regulations in the 12 months prior to this inspection.

Judgment: Not compliant

Regulation 6: Health care

The registered provider had ensured that they had provided appropriate health care for each resident, having regard to that resident's personal plan. However, where a

medical treatment was recommended to be discussed with a general practitioner this had not taken place.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The person in charge had ensured that there were behavioural support plans in place where required. Where restrictive practices were used, the person in charge did not always receive from the the sanctioning committee the relevant completed paperwork that set out the review period.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had systems in place to protect the residents from abuse.

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Birchwood OSV-0006452

Inspection ID: MON-0027085

Date of inspection: 15/01/2020

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: The HSE are consulting with the various agencies used to ensure the provision of all appropriate documentation in line with regulatory requirements. Currently a letter of verification is held centrally in relation to training and qualifications. The PIC is in consultation with the PPIM in relation to streamlining information to be held in the individual centre for those staff that are regularly used from the agencies within the centre.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All outstanding training deficits have been addressed in the schedule due for completion by end of quarter 1.	
Regulation 19: Directory of residents	Not Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: The Directory of residents has been amended to include the previous residents who	

resided at the centre.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The layout of the internal monthly unannounced inspection tool has been adjusted to include an action plan and clear follow up, identification of the person responsible for the action and the due dates of actions.

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The SOP has been reviewed to include details in relation to the exact areas of the property accessible under the lease agreement.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
The PIC has assured that all keyworkers support residents to identify and develop clear skills and goals in line with their assessed needs. A detailed activation schedule has been progressed since inspection to include activities within the centre and in the community. All annual reviews will be completed for residents by the date specified.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: The PIC, registered provider, Assistant Director of Nursing and landlord have met with HSE Estates and HSE architect in relation to the identification of essential works within the centre. A schedule of works has been devised and due for completion by March 31st.	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The HSE Fire Officer has now completed an assessment of the centre and the findings have been communicated to the Registered Provider. The PIC, Registered Provider, Assistant Director of Nursing and landlord have met with HSE Estates and HSE architect in relation to the identification of essential works within the centre following this assessment. While awaiting essential upgrades a Risk Assessment has been completed in relation to fire safety for staff and residents. The risk assessment has been escalated to the General Manager and is included in the Centre's Risk Register. All staff are aware of the instruction for evacuation in the event of an outbreak of smoke and/or fire.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Arrangements regarding inspection of the emergency lighting have now been agreed between the landlord and the Registered Provider. A check on emergency lighting was carried out following this HIQA inspection and a report submitted to the lead inspector. A 3 monthly schedule of emergency lighting testing is scheduled.	
Regulation 5: Individual assessment and personal plan	Not Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:	

The PIC has met with all keyworkers in relation to review and updating of personal plans for all residents in line with their assessed needs, actions plans were devised with feedback and follow up.

Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: The PIC has met with individual keyworkers regarding the importance of ensuring that follow up care and referrals are actioned as necessary.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: Documentation regarding restrictive practice referrals was discussed at the next management team meeting and at the Restrictive Intervention Review meeting. The importance of accurately recording the team's recommendations and implementation of these recommendations for all future referrals was identified and agreed.	

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 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	09/03/2020
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Not Compliant	Orange	31/03/2020
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	Substantially Compliant	Yellow	31/03/2020

	professional development programme.			
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	31/03/2020
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	31/03/2020
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	31/03/2020
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Not Compliant	Orange	29/02/2020
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	Not Compliant	Orange	02/02/2020

	to residents' needs, consistent and effectively monitored.			
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	31/03/2020
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	31/03/2020
Regulation 28(2)(a)	The registered provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.	Not Compliant	Orange	31/03/2020
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	31/03/2020
Regulation 28(2)(b)(iii)	The registered provider shall make adequate	Not Compliant	Orange	22/01/2020

	arrangements for testing fire equipment.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Orange	31/03/2020
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Not Compliant	Orange	31/03/2020
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures 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	Not Compliant	Orange	25/02/2020

	her disability.			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	05/02/2020
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Not Compliant	Orange	05/02/2020
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Substantially Compliant	Yellow	29/02/2020
Regulation 07(5)(c)	The person in charge shall ensure that, where	Substantially Compliant	Yellow	29/01/2020

	a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.			