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:	Oakvale
Name of provider:	Health Service Executive
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	12 December 2019
Centre ID:	OSV-0002463
Fieldwork ID:	MON-0025090

About the designated centre

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

Oakvale provides long stay high support residential care for up to 30 adults with an intellectual disability and/or autism. Oakvale comprises of 5 separate 6 bedded bungalows located in a campus setting in county Cork. All 5 bungalows are joined by a corridor. Two of the bungalows have five bedrooms while three of the bungalows have six bedrooms. Within each bungalow there is a kitchen/dining room, sitting room, bedrooms and bathrooms. Oakvale is the residents' home and is open twenty four hours a day, 7 days a week. Residents are supported by nurses and health care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	25

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
Thursday 12 December 2019	09:30hrs to 18:30hrs	Lisa Redmond	Lead
Thursday 12 December 2019	09:30hrs to 18:30hrs	Caitriona Twomey	Support

What residents told us and what inspectors observed

The inspectors had the opportunity to meet and interact with 15 residents who live in the designated centre. A number of the residents declined to speak with the inspectors, and this choice was respected.

Although a number of residents were unable to communicate their views verbally, the inspectors spent some time in the company of residents and spoke with staff members working in the designated centre. Residents' body language indicated that they were comfortable and relaxed in the designated centre. Staff members were observed interacting with residents regularly, providing meaningful engagement. It was evident that staff members knew the residents well, and that they were aware of their individual needs and preferences.

The inspectors had the opportunity to speak with a number of residents. Residents told the inspector that they were happy with the staff working in the designated centre, and the supports they provided. Interactions between staff and residents were noted to be respectful in nature and it was evident that residents were comfortable in the presence of staff. Residents were aware that they could speak directly with staff members if they had an issue. One resident told the inspectors that they would like the opportunity to cook dinner in their home, with support from staff members. This request was discussed with management in the designated centre.

It was evident from speaking with residents and staff members, that the residents participated in a wide variety of activities. These included shopping trips, going to the cinema and having a drink in a café. Residents were supported to access the community using the designated centre's transport or taxis.

Capacity and capability

The person in charge and staff who met with the inspectors demonstrated a strong commitment to improving the quality of the service provided, and the quality of life of residents living, in the centre. While improvements had been made, there continued to be areas where the provider was required to make further progress to meet the requirements of the regulations.

There were two supernumerary management staff involved in the running of this centre. There were also two managers working in one of the bungalows. All of the management team were based in the centre and were not involved in the management of any other designated centres. There was evidence of regular meetings with managers of local centres that operated under the same

provider. These meetings were used as opportunities for shared learning and to discuss safeguarding issues, complaints and other issues. The person in charge outlined that each staff member had a one-to-one meeting with a member of the management team every year.

An inspector reviewed the annual review of the centre and the two most recent six-monthly visit reports completed by a representative of the provider. The annual review was completed in April 2019. There was no evidence of consultation with residents or their representatives referenced in the annual review, as is required by the regulations. The person in charge showed the inspector eight questionnaires that had been completed by representatives of residents. The information in these was very positive overall. The two six-monthly visit reports were completed in March and September 2019. It was clear that progress had been made in addressing the areas identified for improvement in these reports.

In the course of the inspection it was identified that some rooms in the centre were not accessible to residents. This issue had been identified in the two previous inspections of this centre. The provider had previously provided time frames for these matters to be addressed however had failed to implement the required actions. As such, inspectors concluded that the provider had repeatedly not ensured that the centre was appropriate to residents' needs.

It was identified that at the time of the inspection that the designated centre's policy on the provision of behaviour support, required review. The designated centre had a policy on the use of restrictive procedures. It was explained to the inspectors that the structures outlined in this policy, including a rights review committee, were no longer in place. The registered provider identified that this policy was in the process of review. As a result it was not clear what processes were to be followed to either implement or review any restrictive practices in the centre. The person in charge outlined what they had been doing in the absence of the policy, and also advised that they had postponed a planned audit of the restrictive practices in the centre until the policies were in place.

An inspector reviewed the record of complaints made in the centre. There were handwritten, signed records for each bungalow. These records also included many instances of compliments made regarding the support received by residents. The person in charge maintained a spreadsheet of the complaints for the entire centre. It was identified that at times there was additional information on the spreadsheet that was not included on the signed complaints records for each centre. Examples included some follow up actions and whether the complaint was resolved or not.

There was strong evidence to support that where complaints could be resolved within the centre, they were effectively addressed. There was also strong evidence of staff supporting residents through the complaints process. For example, one resident was unhappy about the use of single use plastic as part of a daily meal. Staff supported the resident to write to the catering department to address this, and again once the matter was resolved. It was identified that in the majority of cases it was not noted whether the complainant was satisfied with the outcome of the complaint, as is required by the regulations. Although there was a space on the

complaints document to capture this information it was repeatedly not completed by staff or addressed subsequently when reviewed by the person in charge or complaints officer.

It was identified that one complaint had not been included on the spreadsheet. This related to residents who shared a bedroom and the negative impact that one resident's presentation had on the sleep of the other. This issue appeared to be ongoing and while there was reference to a long term plan to cease the practice of shared bedrooms there was no immediate plan to address this issue. The person in charge advised that consideration had been given to the five vacancies that existed in the centre. It had been assessed that neither resident would be compatible with the residents in the bungalows with vacancies. As will be discussed later in this report, a risk assessment had not been completed regarding the practice of shared bedrooms. At the time of the inspection there was no satisfactory outcome to this complaint, however it had not been escalated through the complaints processes.

There were a number of complaints relating to access to wheelchair accessible vehicles. Previously residents who required this service had to use a local taxi company. The provider obtained a wheelchair accessible vehicle in February 2019. However, this had not addressed the matter fully and there continued to be issues regarding this matter. Inspectors were assured that the provider was trying to address this issue. However, although this matter was an open, high-rated risk on the centre's register, some of the complaints regarding this matter had been closed.

Due to the healthcare needs of the residents there were nursing staff working in the centre at all times. Many of the staff that inspectors met with on the day of the inspection had been working in the centre for many years and had developed strong relationships with the residents. All observed interactions were respectful and it was clear that staff knew the residents, their needs and preferences well. On the day of inspection, one of the bungalows did not have the full complement of staff due to one staff member being on unexpected leave. The person in charge advised that this would not have a negative impact on residents. Later when reviewing incidents it was identified that a resident had fallen in another bungalow while staff were supporting another resident with personal care. This resident was assessed as requiring staff supervision at all times to ensure their safety. All of the residents of this bungalow require two staff to support them with personal care, however only two staff are rostered to work from 19:00 to 07:00. The inspectors concluded that there was not adequate staffing in this part of the centre to meet residents' assessed needs.

An inspector reviewed a sample of staff personnel files. It was identified that not all of the information as set out in Schedule 2 of the regulations was available in two of the three files. Later in, and following, the inspection, missing information was provided to the inspector for one of the staff members whose file was reviewed.

Staff training records were not available on the day of the inspection. Records for 71 staff were submitted and reviewed by an inspector following the inspection. There was evidence that the provider had a training schedule in place with various sessions arranged up to June 2020. In the information submitted, a number of

trainings were identified as mandatory for the staff team. In the majority of cases, staff whose training had expired were scheduled to attend sessions in the required areas. For example, staff whose training in fire safety, the management of behaviour that is challenging, and safeguarding had expired were scheduled to attend training sessions within the following three months. It was also identified that 19 staff had never received training in communication despite it being identified as mandatory by the provider. There was no evidence that this training was scheduled for these staff.

Regulation 14: Persons in charge

The person in charge was a full-time employee and had the required qualifications, skills and experience to fulfill the role. The information and documents specified in Schedule 2 of the regulations had been obtained by the provider in relation to the person in charge.

Judgment: Compliant

Regulation 15: Staffing

The number of staff was not appropriate to the assessed needs of all of the residents. An inspector reviewed a sample of three staff files. It was identified that not all of the information specified in Schedule 2 of the regulations was available for one staff member.

Judgment: Not compliant

Regulation 16: Training and staff development

Training, identified as mandatory by the provider, was not always available for staff.

Judgment: Substantially compliant

Regulation 19: Directory of residents

On review of the directory of residents it was identified that some of the information required, as per Schedule 3 of the regulations, required review. For example, the date that the resident first came to live in this particular centre was not

always recorded.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management structure in the centre outlined clear lines of accountability. The annual review did not provide for consultation with residents and their representatives, as is required by the regulations. By failing to address identified issues within the time frames they provided in previous HIQA compliance plans, on two separate occasions, the provider had not ensured that the centre was appropriate to residents' needs.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose required review to ensure that the organisational structure included was accurate.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

It was evident that residents were aware of the complaints procedure and were supported by staff to use it. There was also evidence of staff advocating on residents' behalf using the complaints process. Where they could be addressed by staff and the person in charge, complaints were resolved in a timely manner and brought about changes where required. However, there were a number of matters, often those that required input from more senior management, that had been closed that had not been adequately addressed and were outstanding on the day of inspection. It was also not noted in the majority of complaints whether or not the complainant was satisfied with the outcome.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

One policy had not been reviewed in three years, in line with the regulations. The structures outlined in the restrictive procedures policy were not in place at the time of the inspection.

Judgment: Substantially compliant

Quality and safety

The inspectors reviewed the quality and safety of care and supports in the designated centre and found that a number of improvements were required. As noted in a previous inspection, a number of areas including kitchens and visitors rooms were not accessible to residents who were wheelchair users. This had not been completed in line with the compliance plan previously submitted to HIQA, by the registered provider. Maintenance and repairs were required in a number of areas. Some areas also required painting.

The designated centre had fire doors in place. A wooden panel was observed over a number of fire doors. At the time of the inspection, management were unable to provide assurances that these panels provided adequate containment in the event of a fire. Assurances were received from a fire competent person after the inspection, that these wooden panels provided adequate containment.

It was noted that a sluice room had a vent above the door, which did not appear to offer effective containment in the event of a fire. Following the inspection, the provider submitted a report from a fire competent person, to state that that the sluice room did not have, and did not require a fire resistant door set. Further assurances regarding the sluice room were requested by HIQA (Health Information and Quality Authority), however the provider was unable to provide this information from a fire competent person due to the restrictions imposed during the COVID-19 pandemic. It was agreed with the Provider that this assurance would be submitted to HIQA on a future date.

It was observed that an internal door in the designated centre was wedged open by a desk. One staff member also wedged a fire door in the presence of one of the inspectors. A number of fire doors in the designated centre, including bedrooms and laundry rooms did not close fully. The inspectors were not assured that the current fire containment measures were sufficient to ensure the safety of residents within the centre.

Inspectors observed that residents were supported to access and experience a range of activities based on their individual goals. Each individual goal had an associated 'role' which supported and promoted their independence and inclusion in community life. Since the last inspection, an activity room and a multi-sensory room had been added to the designated centre. Staff members in the designated centre had also acquired external supports to provide activities to residents, in line with their assessed needs. Residents were supported to receive visitors in accordance

with their wishes.

The health and wellbeing of residents was promoted and supported in a number of ways. Residents had access to a general practitioner and nursing staff were available to residents when required. A comprehensive health assessment and associated health care plan was available for each resident. The person in charge identified that a number of residents required increasing levels of support to manage their health. It was noted that where heathcare supports were required, that these supports were in place and in line with residents' assessed needs. Pain assessment scales were used to assess the pain of residents who were non-verbal communicators.

The person in charge had ensured staff had the appropriate skills and guidance to respond to behaviours that challenge. Behaviour supports were available to residents if required. PRN medicines (a medicine taken as required), were prescribed to support a numbers of residents to manage behaviour that is challenging. There was sufficient and effective guidance for staff to ensure that that every effort was made to identify and alleviate the cause of the resident's challenging behaviour, and that all alternatives were considered before theses medicines were administered.

The designated centre had a comprehensive safety statement. An emergency plan was also in place, however this had not been reviewed as outlined by the registered provider. A risk management policy, which contained the information set out in the regulations, was reviewed by inspectors. It was noted during the inspection, that two residents shared a bedroom in the designated centre. The person in charge told the inspectors that one of these residents was regularly subjected to sleep disturbances due to the other resident's presentation. This had not been risk assessed by the registered provider. The person in charge identified that they planned to move one resident to a new bedroom when a suitable vacancy arose.

It was identified on the inspection that one resident was currently choosing not to sleep in their bedroom. As an interim measure, the resident was sleeping on a mat in a communal area. Management in the designated centre acknowledged that this was not appropriate and a multidisciplinary review had been scheduled.

Regulation 13: General welfare and development

The registered provider had not provided opportunities for all residents to participate in activities in accordance with their interests, capacities and developmental needs.

Judgment: Compliant

Regulation 17: Premises

The registered provider had not ensured that the designated centre adhered to best practice in achieving and promoting accessibility. This was not in line with the designated centre's statement of purpose.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The registered provider had not ensured that there were effective systems in place for the assessment, management and ongoing review of risk.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had not ensured adequate arrangements were in place for the containment of fire.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The registered provider had ensured that the designated centre had appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that a comprehensive assessment of the health, personal and social care needs of the resident was carried out.

Judgment: Compliant

Regulation 6: Health care

The registered provider ensured that appropriate health care was provided for each resident, having regard to the individual residents' personal plan.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge had ensured that staff had up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

Judgment: Compliant

Regulation 8: Protection

The registered provider had ensured that residents were protected from all forms of 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	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Oakvale OSV-0002463

Inspection ID: MON-0025090

Date of inspection: 12/12/2019

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 2 documents missing from this staff members file are currently being sourced. These will be in his file by the 28/02/19. Staff files will be reorganised to make the specific information required by the regulations easier to navigate. This will be a service wide project and will be completed by 30/06/19. Staffing levels in the center both day and night are sufficient to meet the assessed needs of the residents however it is the current roistering arrangement of staff that needs to be reviewed to address any concerns. A consultation process has been initiated with the various stakeholders in order to progress this.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Training for communication has recently moved onto HSE land, the HSE online training portal. The staff identified as requiring communication training have been instructed to complete same. This will be completed by the 28/02/20.	
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: A full review of the directory of residents will be undertaken and will be completed by 28/02/19 in order to bring it into line with the requirements outlined in Schedule 3.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management:	

In next year's annual review the family feedback will be referenced. This is due by 30/04/20. Family feedback has happened as a matter of course at the beginning of each year for the last number of years and for the previous year (2019). Feedback was largely positive for 2019. This was not included in the annual review for 2019 and this was an oversight on the part of the PIC.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The Statement of Purpose will be reviewed by the 28/02/20 and the term 'Person Participating in Management' will be removed from the organisational structure beside the CNM1's & CNM2.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The complaint regarding the two gentlemen sharing a room was considered when the complaint was made. As was explained on the day of inspection the service has made plans to discontinue the use of double rooms within the centre. This is evident in the minutes of managers' meetings at centre and service level. One of the double rooms within the centre has ceased to be used. As vacancies arise within the centre they are being considered. Due to the two gentlemen's specific needs up until this point no suitable vacancy has arisen for one of them to move into. This has been added to the risk register as of now.
A review of the complaints books has taken place and the books have been changed to make them more user friendly. Whether or not the complainant was satisfied with the response has now been filled out following the review. Greater care to ensure the complaint documents are filled correctly will be taken especially in relation to whether the complainant is satisfied with the outcome.
The issue identified in relation the use of the wheelchair vehicle remains on-going however in the interim residents can avail of the local wheelchair Taxi company.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The policies on restrictive practice & positive behavior support is completed and is being reviewed. This is due for circulation by the 28/02/20

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
It has been identified at previous inspections that some residents have a problem accessing the quiet room due to the door not being wide enough to accommodate a wheelchair. This has been escalated on the centers risk register. Works for same have been coasted and funding has been obtained. A meeting with estates has been

requested to progress this to a stage where works can begin. This will be completed by Dec 2020.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The risk register has been updated and the complaint received on behalf of one of the residents who shares a room has been escalated. As mentioned previously the service does plan to discontinue use of double rooms within the centre. This has happened in one of the two double rooms within Oakvale. No suitable vacancy has arisen as of yet to discontinue the use of the second one. A review of the complaints books has taken place and the books have been changed to make them more user friendly. Whether or not the complainant was satisfied with the response has now been filled out following the review. Greater care to ensure the complaint documents are filled correctly will be taken especially in relation to whether the complainant is satisfied with the outcome.
(Actions Completed)

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The staff member mentioned in the report who wedged the door has been spoken to regarding this matter. He has been scheduled to re-attend fire safety training on the 20/02/20.
The door which was wedged open is supposed to be open using a magnetic fire door retainer however this is broken. Maintenance has been contacted and will repair same by the 28/02/20.
Maintenance have been contacted regarding upkeep of some of the doors and they are due to be on site to complete an inspection of all doors in Oakvale and repair any defects. This will be completed by the 28/02/20.

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	28/02/2019
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.	Substantially Compliant	Yellow	28/02/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training,	Substantially Compliant	Yellow	28/02/2020

	as part of a continuous professional development programme.			
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	31/12/2020
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Substantially Compliant	Yellow	31/12/2020
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	28/02/2019
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	27/01/2020

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	30/04/2020
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	27/01/2020
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	28/02/2020
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	28/02/2020
Regulation 34(2)(e)	The registered provider shall	Substantially Compliant	Yellow	27/01/2020

	ensure that any measures required for improvement in response to a complaint are put in place.			
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	27/01/2020
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	28/02/2020