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:	St Joseph's House for Adult Deaf and Deafblind
Name of provider:	Catholic Institute for Deaf People
Address of centre:	Co. Dublin
Type of inspection:	Short Notice Announced
Date of inspection:	11 November 2020
Centre ID:	OSV-0002090
Fieldwork ID:	MON-0023760

About the designated centre

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

St Joseph's House for Deaf and Deafblind Adults is located in a suburban area of South Dublin. It provides full-time residential services for up to 38 residents. Individuals using the services of this centre are adults and are deaf or deafblind. The designated centre is comprised of one large central building and three wings which contain residential bedrooms and multifunctional spaces. The centre contains 36 resident bedrooms, a number of dining areas, living rooms, bathrooms, shower rooms, hallway and entrance hall spaces, a chapel, a sensory room, a conservatory, staff office spaces, a staff sleep over room, a central kitchen, resident kitchen, larders and store rooms, and a number of utility rooms and clothing airing rooms. Residents are supported by a staff team which is comprised of a person in charge, team leaders, supervisors, a clinical nurse manager, staff nurses, carers, kitchen staff, household staff, drivers, transition team, and maintenance personnel.

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
Wednesday 11 November 2020	09:15hrs to 17:15hrs	Thomas Hogan	Lead
Wednesday 11 November 2020	09:15hrs to 17:15hrs	Valerie Power	Support

What residents told us and what inspectors observed

The inspectors met with a number of residents who were availing of the services of the centre. Residents were observed to be happy and relaxed in the centre and were being supported by staff members through a number of activities. Residents who spoke to the inspectors through an interpreter communicated that they felt safe living in the centre and were satisfied with the services provided. The inspectors observed a number of creative communication tools employed in the centre which included a television screen in public space with a repeating video with staff recorded to remind residents to wash their hands and explaining COVID-19. A family member spoken with informed the inspectors that they felt that their relative was safe while residing in the centre and was satisfied with the care and support being provided.

Capacity and capability

This inspection was completed in response to the receipt of a notification for the planned closure of this centre by the registered provider. In the months preceding the inspection a warning letter was issued to the registered provider by the Office of the Chief Inspector in relation to the absence of a formalised and funded plan for the safe discharge or transfer of residents from the centre before their lease end date of February 2021. In the days following the inspection a decongregation plan was submitted to HIQA by the registered provider along with confirmation of support by the organisation's funders.

At the time of the inspection there were 25 residents living in the centre with two other residents temporarily absent. The inspectors found that while there were noted improvements in key areas since the time of the last inspection, there remained a need for further improvements across a number of regulations. A central finding of the inspection was that while there was ongoing planning for the discharge and transfer of residents from the centre, there was a failure by the registered provider to ensure that developed individual plans were in place for some of the residents who presented with complex needs.

The inspectors completed a review of the centre's staffing arrangements and found that there were appropriate numbers of staff with the right skills and experience deployed in the centre. Staff members were observed to attend to residents' needs in a timely, sensitive and respectful manner. Staff duty rosters were maintained in the centre and a review of these documents found that continuity of care and support was maintained. A review of a sample of staff files was completed by the inspectors who found that a number of documents required to be maintained by the registered provider were not on file. These included signed references, copy of

qualifications, full employment histories, and current employment contracts.

Staff training records were reviewed by the inspectors who found that all staff had completed all mandatory training required by the registered provider. In addition, the inspectors found that there were high levels of completion of additional non-mandatory training within the centre. A review of staff supervision arrangements found that staff members were not appropriately supervised. A review of staff supervision records found that there were considerable deficits in the completion of one-to-one supervision meetings with staff members when compared to the requirements for the completion of these meetings outlined in the organisation's policy on this matter.

The inspectors reviewed the arrangements in place for the governance and management of the centre and found that there had been some improvements overall in the time since the last inspection. The registered provider was found to have completed annual reviews for 2018 and 2019, however, these reviews did not include consultation with residents or their representatives as required by the regulations. Deficits were also identified in the completion of performance management reviews of staff members employed in the centre.

The inspectors reviewed the systems for the management of complaints in the centre. There was a complaints policy in place and there were easy-to-read procedures for making complaints displayed in a number of locations throughout the centre. A complaints register was maintained and this was reviewed by the inspectors who found that 16 complaints had been made to date in 2020. Of these, the inspector found that five had not been appropriately investigated or followed up, and the complainants were not informed the outcome of the complaints process. In all five cases the inspectors found that there was an absence of evidence to demonstrate improvement taking place in the areas referred to in the complaints. Additionally, the inspectors found that appropriate records were not maintained specifically relating to the investigation, outcome and actions taken by the registered provider.

Regulation 15: Staffing

The inspectors found from a review of a sample of staff files that some documents required by the regulations were not maintained. In addition, one staff member employed in the centre was found not to hold a qualification appropriate to their role.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The inspectors found that staff members employed in the centre were not appropriately supervised. For example, in the cases of a number of staff members there had been no one-to-one supervision meetings recorded as having taken place to date in 2020.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspectors found that the registered provider had failed to ensure that a funded plan was in place for the safe discharge or transfer of some residents from the centre in line with their intentions to close the centre in February 2021. In addition, completed annual reviews did not include consultation with residents and their representatives; performance management was not taking place with all staff; and management systems in place required further development to ensure appropriate oversight of care and support being delivered in the centre.

Judgment: Not compliant

Regulation 34: Complaints procedure

A number of complaints made in 2020 were found not to have been investigated or followed up on in an appropriate manner. In some instances, complainants had not been informed of the outcome of the complaints process. There was an absence of evidence to demonstrate improvement by the registered provider in response to complaints made and records were not maintained to a satisfactory standard.

Judgment: Not compliant

Quality and safety

The inspectors completed a full walk through of the centre in the company of the person in charge and chief executive officer. The inspectors found that the premises of the centre were not appropriate for the long term provision of residential services. There were some remedial works completed to the centre in the time since the last inspection and while these were found to improve the aesthetic presentation of the centre, there remained a need for considerable improvements if the centre was to remain open in the longer term. Some areas of the centre remained in a poor state of repair and overall it presented in an institutionalised manner. The premises of the

centre were found by the inspector not to meet the collective needs of residents through its design and layout. Despite this, the inspectors found that the centre was clean and appropriately heated on the day of the inspection.

A review was completed of the supports provided to residents regarding their discharge or transition from the designated centre to other placements in the context of the planned closure of the centre. The inspectors met with representatives of the transitions team employed in the centre and spent time reviewing individual plans. The inspectors found that in some cases there were detailed and comprehensive plans in place for residents, however, this did not extend to all residents. In the cases of some residents with complex needs there was an absence of clear plans for their safe discharge or transition to other placements. Given the advanced stage of the time frame for the closure of the centre, the inspectors found that the absence of developed plans for some residents was a failure to provide appropriate supports.

The inspectors reviewed the arrangements for managing risk in the centre. There was a risk management policy in place which met the requirements of the regulations and there was a comprehensive risk register maintained. There was clear evidence to demonstrate that there were significant improvements in this area in the time since the last inspection. The inspectors found that all presenting risks were identified and assessed and a sample of risk controls reviewed were all found to be in place. A review of a sample of incidents and accidents which had occurred in the centre found that appropriate follow-up actions had taken place where required.

The measures taken by the registered provider to protect against infection were reviewed by the inspectors, who found that a framework had been put in place to prevent or minimise the occurrence of healthcare-associated infections including COVID-19. The centre was observed to be clean throughout and there was appropriate use of hand sanitizer by staff and residents. There were appropriate stocks of personal protective equipment and supplies and all staff were observed to comply with public health guidelines. Information was displayed throughout the centre reminding staff and residents about the importance of hand hygiene and cough etiquette. Staff members had easy access to information on COVID-19 and the relevant policies and procedures.

Fire safety precaution measures were reviewed by the inspectors. There were personal emergency evacuation plans in place for each resident which detailed the individual supports required in the event of a fire or similar emergency. There was a fire alarm and detection system and emergency lighting in place throughout the centre. While there were fire containment measures in place in some areas, these did not extend to bedroom and kitchenette areas in two wings of the centre. The inspectors found that fire drills completed in the centre had not included the full number of residents currently living there since October 2019, and drills completed since that time only included a maximum of 11 residents. While these findings were of concern to the inspectors, the registered provider highlighted mitigating actions taken which included an increase in staffing levels at night time to support residents in the event of a fire. The inspectors were further assured through observation that

breaker fire containment doors has been installed to the entrance of each wing to prevent the spread of fire from one wing to another or to the main central building.

The inspectors reviewed the arrangements in place in the centre to protect residents from experiencing abuse. There was clear evidence that the registered provider had taken significant action to ensure that both local and national policies relating to the safeguarding of residents was implemented in practice in the centre. Despite this, the inspectors observed trends in incidents of a safeguarding nature which involved a small number of residents. There were a high number of low impact incidents occurring on a regular basis which indicated that some safeguarding plans in place were not effective. In addition, the registered provider had not assessed the compatibility of the residents concerned.

The arrangements to support residents with their rights were reviewed by the inspectors. There was evidence of good practice taking place in some instances in this area, however, this did not extend to all residents. For example, external advocacy supports had not been sought for some residents despite significant decisions being made regarding their future residential placements. In the case of seven residents who were highlighted for discharge to a nursing home, none had the supports of an independent advocate and only two had inputs from a social worker. In the case of five other residents, for whom there was no clear plan at the time of the inspection, there was no input from an independent advocate or social worker. This group of five residents presented with complex needs and some ambiguous proposals that were presented by the management team were a cause for concern for the inspectors. There was a clear absence of involvement of the residents or their representatives in this process and it did not actively consider the consent of some individuals concerned.

Regulation 17: Premises

The premises of the centre were found not to be suitable for the long term provision of residential services. In some areas the centre remained in a poor state of repair and was institutionalised in nature.

Judgment: Not compliant

Regulation 25: Temporary absence, transition and discharge of residents

In some cases the inspectors found that residents were not appropriately supported through the development of plans for their safe discharge or transfer from the centre in line with the closure of the centre.

Judgment: Not compliant

Regulation 26: Risk management procedures

The inspectors found that the safety of residents was promoted through thorough risk assessment, learning from incidents and accidents which had occurred and the implementation of a risk management policy in the centre.

Judgment: Compliant

Regulation 27: Protection against infection

The registered provider had taken appropriate action during the COVID-19 pandemic to prevent or minimise the occurrence of the virus in the centre.

Judgment: Compliant

Regulation 28: Fire precautions

There was an absence of appropriate fire containment measures in a number of areas of the centre including bedrooms. While fire drills had been completed in the previous 12 months, these did not include the maximum number of residents and the minimum number of staff to ensure that all eventualities had been tested.

Judgment: Not compliant

Regulation 8: Protection

While there were clear examples of good practice relating to the safeguarding of residents, there were trends observed in incidents which had occurred in the centre which demonstrated the ineffectiveness of some safeguarding plans in use. In addition, some residents involved in reoccurring incidents were not assessed in terms of their compatibility.

Judgment: Substantially compliant

Regulation 9: Residents' rights

There was an absence of appropriate supports from independent advocates for a significant number of residents who were engaging with plans for their discharge or transfer from the centre. In some instances, the process of planning was at an underdeveloped stage and residents were not actively encouraged to contribute to the decisions being made about their future placements. In the cases of five residents there was an absence of evidence to demonstrate that the registered provider considered their consent in the planning process.

Judgment: Not 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 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 25: Temporary absence, transition and discharge of residents	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St Joseph's House for Adult Deaf and Deafblind OSV-0002090

Inspection ID: MON-0023760

Date of inspection: 11/11/2020

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. The Registered provider will continue to ensure appropriate training is in place for all staff. The files have been identified where there were gaps and we are actively working on closing these out by 24th December 2020. 2. The Person in charge has commenced a full audit of all personnel files to ensure compliance with Regulations 15 (5), Schedule 2. The Person in charge will ensure this action is completed by 31st January 2021. 3. Audits on personnel files will take place every 6 months to ensure ongoing compliance. 4. As of September 2020, all new staff only commence employment when all training and documentation is in place.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. The Person in Charge has re-commenced the process of supervision for all staff. 2. All staff will have received supervision by 14th January 2021. 3. The process of supervision will continue on a 3 monthly basis, in line with our revised policy.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. The Registered provider has ensured that there are adequate policies, procedures, protocols, and guidelines in place to guide practice as identified in Regulation 4, Schedule 5.
2. The Person in charge will ensure that clinical risk assessments are carried out on a regular basis and appropriate plans put in place to address needs identified.
3. The Person in charge meets with the service provider on a monthly basis to review systems that are in place in order to ensure that the service is safe and appropriate for residents. These meetings are minuted.
4. The Registered Provider will ensure the annual review is completed by March 2021 and will include consultation with residents and their representatives.
5. The Registered provider will ensure that all annual reviews completed are carried out in consultation with all residents.
6. The Registered provider will ensure that the remaining performance reviews of all members of the workforce will be completed by 31st January 2021.
7. The registered provider will also draft a schedule for all future performance reviews in line with Regulation 23.
8. The Person in charge with the support of the transition and discovery teams will continue to work with residents, family, social workers or other representatives including advocates and HSE in order to support the smooth transition from the centre to a more appropriate setting as agreed with residents.
9. The Person in Charge together with support from the discovery team are in the process of carrying out comprehensive individualized assessments and putting appropriate transition plans in place to address and support individualized assessed needs of all residents who will transition
10. HSE funding has been agreed for each resident

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
1. The Registered provider has carried out an inspection on the outstanding complaint. Complaint closed on 8th Dec. 2020
2. In future the Registered provider will ensure all complaints are investigated promptly.
3. The Registered provider has since the last inspection ensured that the complainants have been promptly informed of the outcome of their complaints and were provided with the details of the appeals processes. In addition the Registered provider continues to ensure that all complaints received are used as an opportunity to improve the quality and safety of care for residents.

4. The Registered provider shall ensure that all complaints received, investigations carried out, outcomes of a complaint, and actions taken will be clearly documented. The complainant will be informed of the outcome and given an opportunity to express their satisfaction or dissatisfaction with the outcome.
5. The Registered provider will ensure all staff are re-familiarised with the complaints policy and procedure to ensure full understanding of the definition of a complaint and the protocols around handling same. This will be completed by 31st January 2021

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. All remaining residents live on the ground floor in the residence. Ground floor accommodation has been identified post Feb 21 in three wings (Riverside, Woodlands and Kinsella). However, we accept the findings of the inspection report and are putting plans in place to address this:

The Registered provider has ensured the following:
a) Put plans in place to commence refurbishment works in all areas of the 3 wings in order to bring it into compliance with Regulation 17. Expected completion date is 15th of March 2021.

b) The Registered provider will ensure that all wings in the residence including Riverside, Woodlands and Kinsella are appropriately maintained, following the refurbishment works. A maintenance plan will be put in place to ensure that all areas are maintained adequately.
c) The premises will be decorated as part of refurbishment works, in consultation with residents. Expected completion date is 15th of March 2021.

Regulation 25: Temporary absence, transition and discharge of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence, transition and discharge of residents:
1. The Person in charge has made arrangements for advocacy services to be provided to all residents who request or require the service. Completion date 23rd December 2020.
2. The Person in charge with the support of the transition and discovery teams will continue to work with residents, family, social workers or other representatives including advocates and HSE in order to support the smooth transition from the centre to a more appropriate setting as agreed with residents.

3. The PIC with support from the Discovery team has commenced the process of engagement with residents around their transition to more appropriate services.
4. This process will support the smooth transition from the centre.
5. All transitions from the centre will be agreed with the Resident and/ or their Representatives prior to the transition taking place.
6. The Person in charge has consulted with each resident and family in advance of a transition taking place. Discharge plans for all residents are drawn up in agreement with each resident where the resident is leaving the service or moving within the service. Where possible (due to Covid 19 restrictions), residents will have an opportunity to visit their new placement/home in advance of the full transition out of the centre by October 2021.
7. The Person in Charge together with support from the discovery team are in the process of carrying out comprehensive, individualized assessments and putting appropriate transition plans in place to address and support individualized assessed needs of all residents who will transition
8. The Person in charge will ensure that support plans are drawn up in consultation with residents and their representative. This will be agreed with residents who are transitioning.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. The Registered provider has a system in place to ensure the safe and prompt evacuation of residents where necessary, in the event of fire.
2. The Registered provider has ensured that all staff and residents are made aware of the protocols to be followed in the case of fire.
3. The Registered provider will continue to carry out regular fire drills (four times per annum). The next fire drill has been scheduled for week commencing 14th December to measure the effectiveness of the evacuation process using night-time staffing levels to stress test the evacuation procedures and put in place any actions/ mitigants as a result of learnings from the process
4. The Registered Provider will ensure staff and residents are re-familiarised with the fire evacuation plan

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The Registered provider has ensured the following:
1. There is adequate recruitment, selection and training procedures in place for staff

2. The Person in Charge has ensured there are behavioral support plans in place for residents requiring the same. The plans will be reviewed, subject to change in residents needs.
3. Residents have access to advocacy services and are actively encouraged to engage with an advocacy service or representative as per resident's preference.
4. Robust reporting systems are in place in the centre
5. All incidents are reviewed weekly with the senior team, action plans are drawn up, risk register updated and support plans are put in place.
6. Staff are informed of changes to the care plans at handovers
7. The Registered provider will put in place quarterly audits to ensure residents understanding of the safeguarding and complaints policies.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The Registered provider shall ensure all residents:
1. who are transitioning will be provided with advocacy in agreement with the resident and their rights
2. Be supported to express their concerns about their transition and supports agreed.
3. are supported to engage fully in the development of their transition plans
4. are supported to visit/virtually or in person where possible, their proposed new home
5. Each resident participates in and consents to all plans regarding their future placement/home
6. Transition plans for all residents are in the process of being initiated and will be closed out by October 2021.
7. Where residents are transitioning out of the service, this will be done in line with the Discharge policy.
8. Five residents will be assisted through the discovery team to explore the most suitable and appropriate placement/home.

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(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	31/01/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	14/01/2021
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	15/03/2021
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Not Compliant	Orange	15/03/2021

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	15/03/2021
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	15/03/2021
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.	Not Compliant	Orange	26/02/2021
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.	Not Compliant	Orange	26/02/2021
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and	Not Compliant	Orange	31/01/2021

	performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.			
Regulation 25(3)(a)	The person in charge shall ensure that residents receive support as they transition between residential services or leave residential services through:the provision of information on the services and supports available.	Not Compliant	Orange	01/10/2021
Regulation 25(4)(b)	The person in charge shall ensure that the discharge of a resident from the designated centre take place in a planned and safe manner.	Not Compliant	Red	01/10/2021
Regulation 25(4)(c)	The person in charge shall ensure that the discharge of a resident from the designated centre is in accordance with the resident's needs as assessed in accordance with Regulation 5(1) and the resident's personal plans.	Not Compliant	Orange	01/10/2021
Regulation	The person in	Not Compliant	Red	01/10/2021

25(4)(d)	charge shall ensure that the discharge of a resident from the designated centre is discussed, planned for and agreed with the resident and, where appropriate, with the resident's representative.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	15/03/2021
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	21/12/2020
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	30/01/2021
Regulation 34(2)(b)	The registered provider shall ensure that all	Not Compliant	Orange	09/12/2020

	complaints are investigated promptly.			
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Not Compliant	Orange	09/12/2020
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Not Compliant	Orange	31/01/2021
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.	Not Compliant	Orange	09/12/2020
Regulation 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.	Substantially Compliant	Yellow	31/01/2021

Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/01/2021
Regulation 09(1)	The registered provider shall ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.	Not Compliant	Orange	01/10/2021
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Not Compliant	Orange	01/10/2021
Regulation 09(2)(d)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has access to advocacy services and information about	Not Compliant	Orange	23/12/2020

	his or her rights.			