



**Health  
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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:	Community Living Area 15
Name of provider:	Muiríosa Foundation
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	02 June 2022
Centre ID:	OSV-0003753
Fieldwork ID:	MON-0035700

## About the designated centre

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

This designated centre comprises of two houses in Co. Kildare. The designated centre provides support to seven residents with varying needs. One of the houses is a large bungalow in a rural setting. There are four bedrooms in the house, with two sitting rooms and a kitchen dining area. The other house is a large bungalow situated in a small cul-de-sac. There are five bedrooms with two en-suites. There is a bathroom, a kitchen-cum-dining room and two sitting rooms. There is a large garden to the rear and front of house. The person in charge shares their working hours between this and one other designated centre, and each house is resourced by a separate team of part-time and full-time direct care and support staff.

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:	6
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

### **1. Capacity and capability of the service:**

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

### **2. Quality and safety of the service:**

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

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

**This inspection was carried out during the following times:**

Date	Times of Inspection	Inspector	Role
Thursday 2 June 2022	10:40hrs to 16:10hrs	Erin Clarke	Lead

## What residents told us and what inspectors observed

This was a focused inspection and was primarily concerned with reviewing the admission and transfer processes, governance and management and positive behavioural supports. While the designated centre consisted of two houses, the inspector of social services only visited one house and met with the three residents living there.

The house is a bungalow in a rural location in Co. Kildare. While the overall capacity for the two houses under this designated centre was seven, this house could accommodate four residents. At the time of this inspection, there were three residents living in this house with one vacancy.

On arrival to the house, one resident greeted the inspector and the inspector spent time with them in their living room. They spoke about a recent hotel trip they had taken with a support staff and that they were looking forward to going away again over the summer. The resident showed the inspector new items that had been purchased for their living room, and it was clear that the resident was involved and consulted with regarding the redecoration of the room. They explained that they felt supported by staff and they were happy to live in the house.

While some residents verbally communicated their views on the support they received in their home, some residents were unable to verbally express their views to the inspector. The inspector met with these residents, observing physical gestures and cues, and residents' interactions with staff members and their physical environment. Residents were observed to be relaxed, comfortable and content as they went about their day.

One new admission had occurred since the previous inspection of June 2021 and by all accounts from the resident directly and from staff this was a positive transition for the resident. It was clear that the resident was informed and involved in the transition and had made several requests for their living environment before moving in. The inspector found that the procedures and guidance for admissions to the centre required review to ensure admissions are based on transparent criteria, are effectively planned for and take into account the need to protect all residents.

The inspector completed a full walk-through of the designated centre in the company of the person in charge. It was found that residents were supported to decorate their bedrooms and shared spaces to reflect personal tastes, interests and styles. Each resident had their own bedroom, and there was evidence of appropriate furnishings, sufficient storage, and adequate shared and private accommodation. The designated centre was found to be very clean throughout and predominantly maintained to a high standard and decorated in a homely manner. There were photographs and artworks on display in the communal areas and in each resident's bedroom.

There were two living rooms in the centre, the first of which was primarily used by one resident and was large in size with ample room for visitors and had recently been decorated. The second living room, located off the kitchen, was a smaller space, and the inspector was informed that two residents liked to spend their time there. When the inspector visited the room, they noted that one corner of the room contained a large office unit with a computer, printer and files. The position of the unit resulted in staff having to sit with their backs to residents. The inspector queried the appropriateness and rationale of having a workspace located in a living room used by residents when there was a separate staff office as it took away from the purpose and function of the room. For example, the inspector observed interruptions to communication with residents due to the noise of the printer, and there was a written risk assessment in place for one resident that expressed displeasure on care plans being worked on by staff in front of them.

A second resident was met with when they returned from day services. They wanted to show the inspector around their bedroom and pointed out items of interest to them, including photos of friends, family and previous residents. It was seen that this bedroom was nicely presented, well maintained and personalised with plenty of storage available for the resident to store their personal belongings.

The views of residents were also available in some of the documentation reviewed during this inspection. For example, the annual review carried out for this centre included the outcome of consultation with residents and families who had been provided with a survey on the services provided in the centre. Feedback from the residents survey confirmed that residents are happy with the service they received. Feedback was also positive from families and they expressed their satisfaction with the quality of care and support that their family member receives and the level of communication they receive. Families said they were looking forward to their family members recommencing activities once restrictions had lifted and this was evident during inspection with residents coming and going from the centre to partake in outings such as visiting the library and going shopping.

In summary, this was a pleasant home where residents were supported by a dedicated staff team and included as active participants in the running of the centre. Residents had a good quality of life in this centre. However, actions were needed in relation to admissions and transfers, governance and management, positive behaviour support, personal planning and residents' rights.

The next two sections of this report present the inspection findings in relation to governance and management in the centre, and how governance and management affected the quality and safety of the service being delivered.

## Capacity and capability

This designated centre had last been inspected in June 2021, where, to minimise movement given the COVID-19 pandemic, only one house of the two houses that

make up the centre was inspected. A high level of compliance was found during that inspection. The purpose of this risk-based inspection was to follow up on unsolicited information received by the inspectorate in December 2021 regarding the transfer and admissions of residents and the negative impact this may have had on the ability of the centre to meet the needs of residents. In response to the receipt of unsolicited information, the regulatory action taken at the time was to issue the provider with an assurance report. Necessary assurances from the provider were received in relation to the issue with no areas for improvement self-identified by the provider. On reviewing the admissions process, the inspector identified that a recent transfer had had successful outcomes for the resident; however, elements of the transfer process required improvement, substantiating some of the information contained within the unsolicited information.

For the purposes of clarity, due to the lines of enquiry that triggered the inspection, only one house was visited by the inspector, upon which the inspection findings are based. The second house was last inspected in June 2021, where 14 of 16 regulations inspected against were found compliant.

As previously mentioned, an internal transfer of a resident had taken place five months earlier. During the inspection, the inspector observed the resident to appear comfortable in their environment, relaxed in the company of staff and supported to express themselves through their personalised living space. However, the inspector found that in relation to the admission process for the resident, documentation and guidance to facilitate a clear planned transfer pathway was lacking.

The inspector reviewed the provider's Schedule 5 policy for admissions, transfers and discharges to determine if the policy informed practice. A schedule 5 policy is an operational policy mandated by the Health Act 2007. These policies should be comprehensive in nature and clearly inform practice. The inspector found that the policy did not provide sufficient guidance as to the procedures and arrangements for pre-admission checks including compatibility assessments that should take place. The inspector found this had impacted the completion of the assessment of needs and personal plans as discussed under quality and safety.

While it was found that improvements were required to the admission and transfer process, the provider had ensured that appropriate staffing arrangements were in place for the increased numbers of residents. Staff also, had transferred with the resident ensuring that the resident's circle of support was undisturbed. These staffing arrangements provided were in keeping with the statement of purpose while providing additional one-to-one staff for residents when required. As part of this, a continuity of staff was provided to support residents while planned, and actual staff rosters worked were maintained. The staff team was overseen by a suitability skilled, experienced and qualified social care leader who was the person in charge.

Team meetings were occurring regularly in the centre, chaired by the person in charge. These were found to be resident-focused so that staff were kept well informed of changes to residents' needs. Standing agenda items included COVID-19, the wellbeing of residents and changing needs, adverse incidents, complaints, risk assessments, quality improvement plans, safeguarding plans and training. For the

formal supervision of staff, arrangements had been made according to the provider's requirements. The inspector was informed that although these sessions were taking place, they were not occurring as frequently as stated and that a schedule had been put in place to make up for the missed sessions. The inspector was unable to assess the training matrix for all necessary training that staff members were required to complete during the inspection; therefore, they asked for a post-inspection update on the status of completed and/or outstanding training. It was determined that most of the training had been completed, with two staff members waiting for their fire safety training.

The regulations also require the provider to have suitable monitoring systems in place to review the services being provided to residents. These are a requirement of the regulations and are important in reviewing the quality and safety of care and support that is provided to residents. The inspector found the provider had carried out a detailed annual review of the quality and safety of the centre for 2021, and there were arrangements for unannounced visits to be carried out on the provider's behalf on a six-monthly basis. The inspector found that elements of the monitoring systems required strengthening in order to effectively identify areas of non-compliance as identified during this inspection in particular the six-month unannounced tool used which was reviewed post inspection.

There was a statement of purpose available that was updated regularly. It contained most of the information required by Schedule 1 of the regulations; however, when reviewing the information on the admission processes, the statement contained limited details and referred back to the provider policy mentioned previously. While the most recent admission was not an emergency admission, the manner in which emergency admissions are facilitated was not laid out as required by the regulations.

#### Regulation 14: Persons in charge

The person in charge was found to be suitably skilled, qualified and experienced to fulfil the role. They were engaged in the governance, operational management and administration of the centre and were present in the centre on a regular and consistent basis.

They managed two houses within the one designated centre and had systems in place to ensure they were maintaining oversight of both centres.

Judgment: Compliant

#### Regulation 15: Staffing

The staffing arrangements in place were found to be adequately supporting residents' assessed needs during this inspection. As part of this a continuity of staff



was provided to support residents while planned and actual staff rosters worked were maintained. The person in charge had prepared a planned and actual roster that accurately reflected the staffing arrangements in the centre. Staff were observed to be knowledgeable about the residents' needs and interacted in a respectful manner with the residents. Where there were any gaps in staffing levels due to leave; these were covered by regular agency staff.

Judgment: Compliant

### Regulation 16: Training and staff development

There was a schedule of staff training in place that covered key areas such as safeguarding vulnerable adults, fire safety, infection control and manual handling. The person in charge maintained a register of what training was completed and what was due. At the time of the inspection two staff members required fire safety training.

Supervision and performance appraisal meetings were provided for staff to support them perform their duties to the best of their ability however, not all staff had been provided with supervision in line with the centre's guidelines.

Judgment: Substantially compliant

### Regulation 23: Governance and management

The centre had a clearly defined management structure in place, consisting of an experienced person in charge who worked on a full-time basis in the organisation and was supported by a local and area manager. There was an annual review of the quality and safety of care available in the centre for 2021. The annual review included feedback from residents and families, and it effectively addressed the quality and safety of care and support in accordance with relevant national standards. The provider had ensured that the centre was adequately resourced and staff were aware of their roles and responsibilities in relation to the day-to-day running of the centre.

In addition, there was evidence of shared learning from other designated centres in the organisation, facilitated through staff meetings. The findings from other inspections were also discussed to proactively address any issues raised.

However, in relation to the governance and management systems in place to monitor the safe delivery of care and support to residents, a review of the six-monthly announced audit was required to ensure that the provider could self-identify areas of non-compliance. The last six-month audit completed for the centre

from January 2022 found a 99.9% compliance rating. The inspector acknowledged the audit tool set out prescriptive criteria and questions. Still, there remained a lack of evidence that the audit served as the registered provider's opportunity to focus on those aspects of the service that needed improvement i.e issues raised from internal audits, previous action plans, quality improvement plans, consultation with residents or staff or a thorough review of the systems in place.

For example, while the inspectorate had taken a regulatory action to request further assurances from the provider in relation to admissions and transfers in December 2021, this was not reviewed or captured in the audit. Only two questions pertained to this area in the audit, both consisting of yes / no answers with no issues identified. Under the governance and management section of the audit tool the seven questions all related to staff knowledge and questions. Overall the inspector found the inspectorate's assessment and judgment frameworks and published guidance were not used to inform the relevant lines of enquiry that are to be explored during each unannounced visit.

Judgment: Substantially compliant

### Regulation 24: Admissions and contract for the provision of services

The provider's policy for admissions and transfer of residents required review to ensure it provides comprehensive guidance to those involved in the aforementioned processes and informed practice. For example, the policy referred to access to Muiriosa services in general, including residential, day, respite and clinical supports. The policy initially devised in 2013, pre-regulation, was reviewed in September 2021. Still, it was unclear to the inspector what changes had occurred during that review as the policy did not reference designated centres or the person in charge, terms that came into existence in 2014. Instead, the responsibility for ensuring the implementation of the procedures were with the regional manager and 'head of the person-centre wing'. Furthermore, information relating to transfers was contained in a separate policy and not a Schedule 5 policy as required by regulations and therefore not subject to three minimum yearly reviews; the date of the last review was June 2016.

Judgment: Not compliant

### Regulation 3: Statement of purpose

There was a statement of purpose available that was updated regularly. It contained most of the information required by Schedule 1 of the regulations; however, when seeking additional information on the admission processes, the statement contained limited details and referred back to the provider policy mentioned previously. Also,

the manner in which emergency admissions are facilitated was not laid out.

Judgment: Substantially compliant

## Quality and safety

While the inspector found that the overall lived experience of residents availing of the services of the designated centre was positive, some areas of improvement were identified through the inspection process. Three of the four regulations inspected against relating to quality and safety found areas of improvement were required. Despite this, the inspector found examples of good practice, which included the involvement of residents in shaping the service received, the development of and maintenance of relationships with the local community and personal networks of residents, and the monitoring of healthcare needs.

Residents participated in a range of activities both at the centre and in the local community, which reflected their personal choices and assessed needs. Residents were supported to attend day services in the local area for set days during the week, as well as being supported by the centre's staff on their off days where they did activities of their choice such as personal shopping. Due to the centre's rural location, the provider further ensured residents had access to local amenities through the provision of two vehicles at all times.

As required by the regulations, residents had individual personal plans. Such plans should reflect the needs of residents and provide guidance for staff in supporting these needs. The inspector found that where an internal transfer had occurred, the requirements of the regulations were not followed in assessing needs prior to admission resulting in the delayed development of a personal plan. However, the inspector found that the majority of the residents' plans reflected the residents' continued assessed needs and outlined the support required to maximise their personal development in accordance with their wishes, individual needs and choices.

One area the inspector found was impacted by the lack of a comprehensive assessment of needs completed prior to admission to the centre was the provision of behavioural supports. It was clear from meeting with staff and reading the documentation that support was required in this area. From reviewing the behavioural support plan in place, it did not refer to these behaviours or the new shared living environment. These behaviours included destruction of property and verbal aggressive behaviour. Having such plans is important to ensure that staff have tailored and specific guidance when supporting residents in this area.

Residents' healthcare needs were met to a high standard in the centre. Each resident had received an annual health check with their General Practitioner (GP). There was evidence of good coordination of residents' varied health care needs between the residents' GP and the service, including escalating access to specialist care where required. Appointments with allied health professionals were logged, and

the advice and guidance from these professionals were then updated into residents' personal plans.

### Regulation 5: Individual assessment and personal plan

For the most part residents had individual personal plans in place which had multidisciplinary input and were subject to a person-centred planning process. Improvement was required to ensure that new admissions to the centre have a comprehensive assessment covering the health, personal and social care needs prior to admission to the residential centre. This is so that any identified risks are assessed and supports made available to ensure the resident's safety and welfare and to ensure the safety and welfare of the existing residents in the centre. The inspector found the assessment of need was completed two months after admission and care plans four months after admission as opposed to 28 days as laid out in the regulations. As part of the findings under this regulation the inspector acknowledged that familiar staff had transitioned with the resident along with personal plans from the resident's previous centre.

Judgment: Substantially compliant

### Regulation 6: Health care

Appropriate healthcare was made available to residents having regard to their personal plans. Plans were regularly reviewed in line with the residents' assessed needs and required supports. They had assessments in place, and specific health management plans and health monitoring plans were developed and reviewed as required. For example, monthly weights were being completed as part of a health action plan, and there was clear guidance if any changes occurred. Staff spoken with demonstrated a good understanding of residents' health needs and the requirements in place to promote and maintain good health, for example, individual-specific feeding and drinking guidelines.

Judgment: Compliant

### Regulation 7: Positive behavioural support

Some relevant guidance was available for staff supporting residents to engage in positive behaviour, and it was also noted that all staff had received the relevant training in positive behavioural support. This was complemented by an exploratory workshop whereby transferring staff provided information to better understand the

strategies in managing behaviours of concern.

However, when reviewing the behavioural support plan for the resident, it did not reference behaviours that were documented and reported through the incident reporting systems. It was not evident that these incidents were reviewed through the positive behavioural support processes for the effectiveness of the behavioural support plan. It was also unclear from the incident reports the impact they may have had on other residents or not. Nevertheless, there was no risk assessment in place relating to the impact that this resident could have on the peers they were living with. Having such plans is important to ensure that staff had tailored and specific guidance when supporting residents in this area.

Judgment: Substantially compliant

### Regulation 9: Residents' rights

Residents were consulted in the running of the centre and in decision making through monthly resident meetings and through the annual report consultation process. The inspector observed communication and interactions between staff and residents and found it to be caring and respectful at all times. Residents rights were respected in the centre with residents having choice and control in their daily lives. Improvement was required in one area of the house where office-based equipment and activities impacted the residents' living space and personal information.

Judgment: Substantially compliant

## Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
<b>Capacity and capability</b>	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
<b>Quality and safety</b>	
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

# Compliance Plan for Community Living Area 15 OSV-0003753

Inspection ID: MON-0035700

Date of inspection: 02/06/2022

## Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant** - A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.
- **Not compliant** - A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

## Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

### Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>A training matrix is in place detailing all training records. The two staff members identified have now completed all mandatory training.</p> <p>While all staff supervisions had taken place, they were not recorded and available to view. This is currently being updated and a matrix set up to help support the process.</p>	
Regulation 23: Governance and management	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>A number of reviews have taken place with regards to the internal 6 and 12 month auditing process. Following this, an information session took place with The Nurse Practice Development coordinator and Persons In Charge on 30th June 2022 to reiterate the importance of being more thorough when conducting internal audits and paying closer attention to triangulation.</p> <p>The 6 and 12 monthly audits will be reviewed to ensure they meet the regulations.</p>	



Regulation 24: Admissions and contract for the provision of services	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:  The Admissions &amp; Discharge Policy will be reviewed to ensure it meets the regulations including information in relation to transfers and clear guidelines for the admissions process.</p>	
Regulation 3: Statement of purpose	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 3: Statement of purpose:  The Statement of Purpose will be reviewed to ensure it meets the regulations.</p>	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:  The assessment of need plus the personal plan will be reviewed and updated prior to any future planned transitions. The purpose of which, is to identify any risks and to make sure supports are made available to ensure the residents safety and welfare and to ensure the safety and welfare of the existing residents in the centre.</p>	
Regulation 7: Positive behavioural support	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:  The positive behavior support team have committed to re-commencing monthly or bi-monthly team reviews of proactive supports and to identify and provide tailored and</p>	

specific guidance in relation to supporting all residents. A review will also occur of the behavioural support plan to make sure it is inclusive of all identified behaviours and a review of risk assessments.

Regulation 9: Residents' rights

Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: A meeting was held with the residents on the 03/06/2022 to discuss the layout of their home and in particular office-based equipment. While the residents indicated they were happy with the current location of equipment they had no objections to the office-based equipment being re-located to the staff room. This will be arranged once the necessary works have been completed.

## 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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	20/06/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	22/07/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	15/07/2022
Regulation	The registered	Not Compliant	Orange	31/10/2022

24(1)(b)	provider shall ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.			
Regulation 24(4)(b)	The agreement referred to in paragraph (3) shall provide for, and be consistent with, the resident's needs as assessed in accordance with Regulation 5(1) and the statement of purpose.	Not Compliant	Orange	31/10/2022
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	31/08/2022
Regulation 05(1)(a)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.	Substantially Compliant	Yellow	15/07/2022
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the	Substantially Compliant	Yellow	15/07/2022

	resident which reflects the resident's needs, as assessed in accordance with paragraph (1).			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	30/09/2022
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Substantially Compliant	Yellow	25/08/2022