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:	Ladywell Lodge
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Louth
Type of inspection:	Short Notice Announced
Date of inspection:	23 July 2020
Centre ID:	OSV-0003025
Fieldwork ID:	MON-0029983

About the designated centre

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

Ladywell Lodge is a centre situated on a campus based setting in Co. Louth. It provides 24hr residential care to up to ten adult male and female adults some of whom have complex medical needs. The centre is divided into two separate units which are joined by a communal reception area. Each unit comprises of a large dining/sitting room, additional small communal rooms, adequate bathing facilities, laundry facilities and an office. Residents have their own bedrooms. There is a large kitchen shared by both units where residents can prepare small meals and bake. Meals are provided from a centralised kitchen on the campus. Both units have access to a shared garden area where furniture is provided for residents use. The centre is nurse-led meaning that a nurse is on duty 24 hours a day. Health care assistants also play a pivotal role in providing care to residents. The person in charge is responsible for one other designated centre under this provider. They are supported in their role by a clinic nurse manager in order to ensure effective oversight of this centre. Residents are supported to access meaningful day activities by the staff in the centre and have access to a "hub" on the grounds of the campus where they attend some activities. A bus is available in the centre which is shared between the two units to support residents accessing community facilities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

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 23 July 2020	10:20hrs to 18:15hrs	Christopher Regan-Rushe	Lead

What residents told us and what inspectors observed

Due to the current COVID-19 global pandemic, the inspector completed the majority of this inspection in the main offices of the provider's buildings on this campus. The inspector completed a short walk-around of this service at the end of this inspection. During this walk-around the inspector met two residents out of the nine residents living in the centre on the day of inspection. Both residents, while unable to verbally communicate with the inspector, appeared to be very well and were relaxing in their rooms or the communal areas of the centre. The inspector noted that the residents appeared to be happy and responded to the verbal queues offered by the inspector and staff on duty.

The inspector was able to view two resident's bedrooms, while ensuring that appropriate social distancing measures and personal protective equipment (PPE) was being used. The inspector noted that the residents' personal spaces were bright and airy and they were individually decorated. In one bedroom the inspector noted that the resident had a number of objects of interest suspended from their ceilings, while in another, there were pictures of family members evident.

Staff interactions with the residents were observed to be warm and meaningful, and it was clear to the inspector through these observations that the relationship between residents and staff was respectful while both caring and mutually rewarding.

Capacity and capability

On the whole, the provider and person in charge were able to demonstrate how their governance and management arrangements were ensuring that the service being provided was safe, was subject to regular and appropriate review and was of a suitable quality to ensure that residents were able to enjoy and participate in meaningful lives, with the right support, in the right way - at the right time.

While elements of the residents' lives were currently being negatively impacted by the COVID-19 global pandemic, the provider, the person in charge and the staff working with the residents, were able to demonstrate their commitment to continually improving the quality of the service, and ultimately better outcomes for the residents, through these systems and processes. However, while this was evident in the provider's newly developed systems, some improvements were required to ensure that there was consistency in how improvement actions, which had been self-identified or arose from their audits, were being tracked and completed.

The provider had completed a number of audits in relation to the oversight and management of the centre, including a recent regulation 23 unannounced visit, a medicines management audit and restrictive practices audit, which were reviewed by the inspector. While the inspector found that these were of a good quality, relevant to the line of enquiry being audited and noted both the good practice and the improvements required to key areas, the inspector found that the actions arising from these audits were not being consistently maintained and tracked. For example, in some audits the actions and time frames for completion of the actions were noted in the audit tool, in others they were documented on a newly developed Quality Enhancement Plan [QEP] document - which was kept live and on the organisation's computer systems. However, in another audit the inspector noted that an action that had been identified in the audit had not been included in the audit action plan but had subsequently been documented in the QEP.

In another example, the provider had recently introduced a revised individual personal planning structure and these were now subject to annual audit in order to ensure the consistency and quality of these records. The inspector reviewed the audits of four residents' records. In the audits of the residents' Individual Personal Plans, it was noted that a number of actions or improvements had been identified by the reviewer. However, there was again no evidence of a target date for these to be completed, or confirmation in the audit that the actions had been resolved.

Overall, the inspector found that the lack of consistency in the documentation and completion of actions meant that while the provider was able to demonstrate that there was an overarching processes for the oversight of the service and a mechanism for capturing and driving improvements, the different ways of recording timescales or actions either on the audit or in the QEP could lead to confusion. This was of particular relevance as the person in charge confirmed that the majority of staff did not have access to the online version or an up-to-date copy of the QEP to help them keep up to date with any progress. In addition, the various ways in which actions could be recorded and updated either in the QEP or on the audit tool, could lead to actions being missed or updates to the actions being recorded in the wrong place.

The provider had completed a statement of purpose which clearly described the service and the nature of support that could be offered to residents living in the centre. The statement of purpose included all the elements required by the regulations. However, within the statement of purpose the number of centres supported by the person in charge was incorrect, this meant that the cover available from the person in charge to this centre was inaccurate.

The provider had appointed a suitable number of staff with the appropriate qualifications and skill mix to meet the needs of the current resident cohort. There were both nursing staff and support staff on duty and the number of these on duty on the day of the inspection, matched the planned roster for the day. Four staff records were reviewed during the course of the inspection and the inspector found that while the majority of information required in Schedule 2 of the regulations was present, in two staff files the evidence of a full employment history was incomplete.

There was evidence that the training and development of staff began upon the commencement their employment with the organisation. Induction training records, in the main, demonstrated that each member of staff had undergone a form of induction to the service, including orientation to the unit and the residents. In addition, staff had to complete a fire safety induction into the designated centre upon commencement with the service. Of the four staff training records reviewed by the inspector, it was noted that while all these documents had been completed by the new staff member, in some instances the person supervising the induction had failed to sign the document. This meant there was limited evidence available in these records to demonstrate that staff were receiving a consistent induction or that they were being suitably supervised throughout their respective inductions. Therefore the provider could not be assured that these staff were suitably equipped with the necessary knowledge and skills to adequately support the residents or to evacuate in the event of a fire.

The person in charge was aware of the need to submit notifications for certain events to the chief inspector. The inspector found that all such notifications had been submitted, as required by the regulations, via the provider portal. In addition, and where required, the person in charge had taken suitable actions in relation to the events leading up to the submission of these notifications. There were a number of restrictive practices in place in the centre and the person in charge had notified the chief inspector of these on a quarterly basis as required by the regulations.

The provider had reviewed their record retention procedures, in light of the findings from the last inspection, and now has an appropriate retention schedule in place.

Regulation 15: Staffing

Improvements were required to the schedule 2 records to ensure that all required elements were being held on each staff members files.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Records which evidenced the supervision of staff through their inductions programmes needed to be fully completed.

Judgment: Compliant

Regulation 21: Records

The provider has reviewed their record retention procedures, in light of the findings from the last inspection, and now has an appropriate retention schedule in place. In addition, the provider has introduced a new individual personal planning structure for the management of key residents records and these were now noted to be subject to regular audit in order to ensure the consistency and quality of these records.

Judgment: Compliant

Regulation 23: Governance and management

Overall there was good evidence of the oversight and auditing of the service and improvements had been made to how the actions from these were being recorded and achieved. However; a consistent approach to this across all such audits is needed to ensure that the risk of not completing an action was minimised, that staff were kept up-to-date with the actions and their progress and that there was a consistent methodology / system in place for documenting and recording audit outcomes.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The person in charge's hours in the centre, as a representation of their whole time equivalent hours, were recorded incorrectly in the statement of purpose and needed to be amended.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The provider was submitting all notifications to the chief inspector as required by the regulations.

Judgment: Compliant

Quality and safety

While there are plans to de-congregate and close this centre in the future, due to its campus-based location, residents living in this centre were able to enjoy good quality lives, free from the risk of harm, in a safe and caring environment. Residents had received comprehensive assessments of their needs which they were being actively supported with. However, there were areas in the overall quality of the environment that continued to impact on the residents daily lives, such as the cleanliness of the premises, the quality of some of the soft furnishings and an ongoing issue with a fire alarm repeater sounding in the designated centre unnecessarily.

The inspector reviewed four resident's files and found that each of these contained a very comprehensive assessment of the resident's health and social care needs. These were supported by newly developed individualised personal plan folders, the inspector found that these were also very comprehensive, were easy to use and navigate. Each personal goal or healthcare need was supported by a document set for recording progress and actions against the outcome. In addition, there was evidence that the goals or needs were subject to regular review.

Residents, and where appropriate their family representative, had been involved in the development of these plans and there was evidence that the resident's key workers had spent time exploring different and diverse activities for residents to participate in. The inspector saw a number of examples of where the key worker had identified activities that the resident would like to do when they were in a good mood and the activities that they preferred to do or not do when they were feeling less happy. These had been developed into a guide for staff on a single page. The inspector found that these were easy to interpret and provided staff with a range of opportunities to engage residents in activities they liked to do at various stages of the day. Usually many of the residents would participate in day programmes or attend the local activation hub, where they could participate in a variety of activities. However, as a consequence of the current pandemic these activities had ceased. However, the provider had redeployed some staff from day services who were working within the designated centre to support residents have an active day.

Residents living in this centre had very complex presentations which required often high levels of nursing interventions. For example; a number of residents had permanent feeding tubs and required a high level of support from clinical staff in the management of these. Other residents had a number of other health related needs which required the input of many different professionals. The inspector found that the provider was ensuring that these needs had been appropriately assessed by a multi-disciplinary team and that each need had its own care plan and treatment plan. The inspector reviewed these records and found that they were being kept up-to-date and there was good evidence contained in the records of adherence to the protocols for the care and support of each of these needs. The inspector also noted that these plans were subject to regular review and included key health and allied healthcare professional.

Some residents had completed advanced directives in relation to their future care

and support needs, including what should happen in the event of their death. It was evident to the inspector that a great deal of care and attention had been spent on the development of these documents, and included the view of representatives from the residents family and core treatment teams. The inspector reviewed these directives and noted that some residents had 'do not actively resuscitate' (DNAR) statements in place. These had been agreed with the resident's treating medical doctor. The inspector reviewed these and found that they were sensitive to the resident's and their family's wishes. There was an arrangement in place for the DNAR's to be reviewed at least every six months to ensure they remained consistent with the resident's and their family's wishes.

The provider had appropriate arrangements in place to safeguard residents from the risk of harm. Following a recent safeguarding concern, the inspector noted that the provider and the person in charge had responded quickly to the concern and had reported this to appropriate agencies, including the designated officer, the HSE and An Garda Síochána. At the time of the inspection the safeguarding investigation is ongoing and is yet to be concluded. However, the inspector noted that the provider had put in place an interim safeguarding plan to ensure that the resident would not be exposed or subject to a future risk of the same event occurring in the future. While the majority of elements in this plan had been implemented, one action - to develop a story board for a certain issue, had yet to be completed.

The provider had ensured that there was now a clear mechanism in place to monitor the servicing of all clinical equipment used in the designated centre. The inspector reviewed all records relating to the servicing of this equipment and found that there were up-to-date records of the service history of each item and that, where it was required, specialists had undertaken the servicing and repair of specialist equipment.

Each resident had their own room, which was individually decorated. While the inspector did not visit each room, it was noted that significant repairs had been undertaken to the ceiling in one room, which had been found to be in a poor state of repair at the last inspection. In another room, the inspector found that works planned to renovate and increase the space available for another resident had been completed. The inspector noted that there was a maintenance register in place and that there was evidence of required environmental repairs being escalated by the staff for repair.

The inspector completed a walk around of the designated centre and found that on the whole this was bright and airy and clear from clutter. However, the inspector noted that that some improvement was required to the overall cleanliness of the designated centre. For example, there was evidence of the development of some cobwebs and in one visitors room there was evidence of recent staining on the walls. In addition, the person in charge advised the inspector that recently installed head height heaters located throughout the centre had not been included on the cleaning schedule. The inspector spoke about this with the person in charge who informed the inspector that nursing and health care staff were being utilised to clean the centre, as the house keepers hours were now part of the overall skill mix of the service. The inspector found that the requirement for the nursing and support staff being required to clean the premises, coupled with the complexity of residents

needs in the centre, resulted in the cleaning tasks not being completed or maintained to a consistent standard.

The inspector also noted that there was some soft furniture throughout the centre, such as arm chairs and sofa's in need of repair. The person in charge of the centre advised the inspector that they had been given authorisation to replace these but they had been unable to do so due to delays in delivery times created by the COVID-19 outbreak. However, it was noted that these chairs were not generally in use by residents and were in the main used by staff or residents. Notwithstanding, these items required replacement.

The central heating system in this centre is no longer operational and the provider has put in place an alternative arrangement, in the short term, until such time as a suitable alternative house in the community can be found for the residents to move into. Previously the provider had installed floor based oil filled heaters, that could be thermostatically controlled. These could be monitored centrally, to ensure that an appropriate temperature could be maintained in the centre. On the day of the inspection it was very warm in the centre and these heaters were off, with a number of these unplugged from the wall. In addition, the provider had now moved these heaters from the floor on to shelves so that they were at head height. This arrangement while suitable in the short term, continues to be unsatisfactory.

The provider had put in place suitable measures to protect against the risk of infection. The inspector found that the provider was complying with the current public health guidelines on the prevention of a COVID-19 outbreak. There was evidence that staff temperatures and symptoms were being monitored on a daily basis and that all residents and staff had received a COVID-19 test which had been confirmed as negative.

There was appropriate signage in place in relation to the management of the risks associated with COVID-19 and the inspector observed numerous hand cleaning and sanitising stations around the premises. Staff were wearing appropriate PPE when working in close proximity with residents, each other or when completing key tasks where the risk of infection was increase; in line with current guidelines.

The provider had ensured that the actions relating to fire safety, arising from the last inspection, had been fully completed. There was evidence that the fire doors in place had been certified by an appropriately qualified person. The provider had reviewed their arrangements for the safe and timely evacuation of residents in the event of an emergency, including fire, and had introduced a new protocol for completing simulated fire drills, including for a night time evacuation. The inspector reviewed fire evacuation records and noted that the provider had completed a recent drill which involved a horizontal zone evacuation to good effect. The inspector also noted that there were regular checks in place of all fire safety equipment, including emergency lighting, doors and extinguishers.

Resident's personal emergency evacuation plans (PEEPs) were reviewed by the inspector, these were found to have been recently reviewed and of a sufficient quality to guide and support staff in the effective evacuation of residents. For

example, these included details of the equipment that a resident may require to support an evacuation, where this was located, how to use it and how many staff should be involved in evacuating the resident. The PEEP's also included information on horizontal evacuations and what to do in the event that a resident may refuse to evacuate the premises.

During the last inspection it was noted that the fire alarm panel in the designated centre would sound in the event of a fire in any part of the campus. This meant that residents in this centre would be disturbed by the alarm even if this was not as a result of a test or a fire in their own home. The provider has undertaken a review of this and is currently exploring options for this to be resolved. However, at the time of the inspection the issue remained and continued to be an unreasonable intrusion on the residents rights.

Regulation 17: Premises

The overall attention to cleanliness in the centre required attention. In addition some soft furnishing required replacement. The arrangement for heating the centre while satisfactory in the short term, remained unsatisfactory in the long term.

Judgment: Not compliant

Regulation 27: Protection against infection

The provider had adequate precautions in place to protect against the risk of infection.

Judgment: Compliant

Regulation 28: Fire precautions

There were suitable precautions in place to detect, contain and prevent the risk of fire. Residents PEEPs were comprehensive and provided a clear guide to staff in supporting the sage evacuation of the centre.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The residents were supported to have active lives and had participated in their assessments and reviews. Each resident had a clear personal plan and was being supported by their individual key workers to achieve their goals.

Judgment: Compliant

Regulation 6: Health care

Residents were supported to achieve the best possible health. They had access to appropriate professionals who had developed clear support plans for staff to follow. Where required, residents had developed advance directives to ensure that their future care was delivered in line with their wishes.

Judgment: Compliant

Regulation 8: Protection

There were appropriate arrangements in place to safeguard residents from the risk of harm. Where required, residents had a safeguarding plan in place to reduce the risk of future harm. One action arising from an active safeguarding plan was not complete in line with the safeguarding plan.

Judgment: Substantially compliant

Regulation 9: Residents' rights

While overall residents rights were being protected, an issue with the fire alarm system sounding in their home unnecessarily continued to impact on their rights.

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 - 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	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Ladywell Lodge OSV-0003025

Inspection ID: MON-0029983

Date of inspection: 23/07/2020

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: Gaps in employment history in the two staff files will be updated. Employment history for future employees will be clarified during the interview process	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Auditing within the designated centre will continue to be conducted by the Person in charge & Clinical nurse managers as per their auditing schedules. Peer auditing will recommence when covid restrictions allow for this. The Person in Charge and Clinical Nurse managers will agree actions from the audit findings. All actions and timeframes for completion will be recorded on the centres Quality enhancement plan (QEP) A copy of the QEP has been made assessable to the staffing team and the actions are discussed at the designated centres team meetings	

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 for the designated centre has been amended to reflect the Person in Charges correct WTE for their areas

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Any maintenance works highlighted within the Designated centre have been escalated to the Operations Manager & maintenance supervisor and a schedule of works has been developed for the completion of works.

Items of furniture that are in poor state of repair are identified and are being replaced through the procurement process.

Cleaning schedules will be reviewed on an on-going basis to ensure they are effective within the designated centre. Audits of the area will ensure compliance with cleaning schedules.

Technical specification in preparation for tender has been completed and the eTender will now be compiled for the electrical heating system.

The eTender process will commence and awarded with time for contesting of award allowed so identification of contractor will be by October 2020, with a final date of works completion by December 2020.

Completion date will be made a factor in the eTender process to ensure as soon as possible completion

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The outstanding action on the safeguarding plan, to develop a social story for the resident has being completed and introduced.

Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: A test system has been identified for the fire alarm system, whereby the sounders can be muted manually while the planned tests are taking place. This will eliminate any alarm sounds from the total testing protocols. This will be installed by end September 2020	

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	04/09/2020
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	30/12/2020
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/10/2020
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate	Substantially Compliant	Yellow	20/08/2020

	to residents' needs, consistent and effectively monitored.			
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	23/07/2020
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	27/09/2020
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	30/09/2020