Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	South Clondalkin
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Dublin 15
Type of inspection:	Unannounced
Date of inspection:	31 January and 01 February2019
Centre ID:	OSV-0003921
Fieldwork ID:	MON-0023372

About the designated centre

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

South Clondalkin designated centre, as part of St. John of God, Liffey Services, provides residential services to male and female residents over the age of 18 in two locations in the community. The maximum capacity of the combined service is nine residents. One house, a semi detached bungalow has four bedrooms available to residents, a sitting room, a kitchen dining area, showering and bathing areas and an utility area. The other house is a two storey detached house with five bedrooms available to residents. One bedroom on the ground floor is accessible with an ensuite. There are separate showering areas off the kitchen and upstairs. All residents have access to multi-disciplinary team including social workers, physiotherapists, occupational therapists, speech and language therapy and psychology. Residents in this designated centre are supported to avail of meaningful day services. The day service the individual attends depends on the individuals' needs and preferences. The residents are supported to access the community and access work and education opportunities through these day services. Where a resident has chosen not to attend a day service he/she is supported to avail of a meaningful day from their home through activities in the community.

The following information outlines some additional data on this centre.

Current registration end date:	31/10/2020
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
01 February 2019	08:30hrs to 15:00hrs	Erin Clarke	Lead
31 January 2019	09:00hrs to 16:30hrs	Erin Clarke	Lead

Views of people who use the service

The inspector met and engaged with four residents in line with their assessed needs during the inspection and observed elements of their daily lives. The inspector observed very positive interactions between residents and staff. It was clear residents were comfortable in the company of staff. Staff engaged positively with residents and demonstrated that they knew and understood the individual communication needs of residents. Although a number of residents were unable to tell the inspector about their views of the service, the inspector observed warm interactions between the residents and staff caring for them and that the residents were in good spirits. One resident indicated to the inspector that they liked living in the centre and the staff that provided support to them.

It was noted by the inspector that the residents were familiar with the person in charge and interacted in a very positive manner with them. Residents were actively supported and encouraged to maintain connections with their families through a variety of communication resources and facilitation of visits.

Staff spoken with outlined how they advocated on behalf of the residents and how they felt that each of the residents enjoyed living in the centre.

Capacity and capability

Overall the inspector found that the governance and oversight arrangements in the centre needed improvement, whilst there was evidence of good management structures and oversight of resident care needs in the centre, certain areas of service provision were not effectively monitored to ensure that timely corrective and remedial action were taken when issues arose. As a result of this the quality of life which residents experienced was negatively impacted. For example, the provider's monitoring systems had not highlighted that the designated centre required a deep clean, repairs to bathroom and kitchen facilitates, painting and general upkeep of the properties.

The provider had carried out annual reviews and unannounced visits at the required intervals, however improvements were needed in the effectiveness of these audits as they were primarily documentation reviews and did not include a thorough walk-about of the service to identify improvements required. While the views of residents and their family representatives were sought these were not clearly captured in the report.

The most recent unannounced audit by the provider to review the quality and safety of care provided had been carried out three weeks before this inspection. However, while some of the findings of the provider's own internal management systems were also evident during this inspection, they did not identify some important failings which impacted on resident's safety and well-being. For example, it was identified

by the inspector that there was infection control issues, omission of local procedures to guide staff in the safe administration of medication and a lack of a time bound plan to upgrade the properties. The last annual review completed in February 2018 did refer to some of the pertinent issues related to residents' quality of life and safety; such as exploration of a stair lift and enhancements to the property, however it did not influence action or deploy resources to address these concerns. Within the statement of purpose it was stated that Liffey Services Maintenance, the Housing Association and Household Departments shall maintain the buildings and grounds, make arrangements for toilet, washing and bathing facilities to be adequate, and to ensure that the environment is hygienic and in good repair. As a result the inspector was not satisfied that the facilities provided to meet the care and supports needs of the residents, as declared in the statement of purpose, were adequate.

The person in charge commenced their role the week of the inspection but had worked in the designated centre for the previous year as a social care leader and was therefore found to have a good understanding of the service which was provided to the resident's and of their care needs. They were in a full time role and found to be actively engaged in the day to day operation of both houses prior to undertaking the role of the person in charge. They were responsible for the supervision of staff and had implemented an effective system of supervision that was relevant to the needs of staff members and it ensured that they performed their duties to the best of their abilities. There was a planned schedule of supervision for the forthcoming year which ensured it was regular, proactive and afforded time to staff to prepare for these sessions. There was a clear training matrix maintained which indicated that all staff had the required training elements. The person in charge also had oversight of the training completed by external agency staff to ensure that the required mandatory and resident specific training had been completed.

Due to a sudden change in needs for one resident the provider had responded by implementing a live night shift which began in December 2018 to support these needs. Currently a large number of internal relief and external agency staff were being utilised to cover these shifts, whilst this arrangement did not promote a continuity of care and provide staff that were familiar to the residents it was recognised by the provider that this was an emergency measure until staff could be recruited in the role. The person in charge had ensured that all agency and relief staff had completed induction to the service before commencement of their shift. Following the inspection the provider had submitted an up to date statement of purpose that reflected the increase in the staff numbers, required to meet the needs of all residents. The statement of purpose required minor adjustments to the floor plans, to reflect the change of use in one bedroom and prescribed layout requirements.

Regulation 14: Persons in charge

The person in charge was suitably qualified, dedicated to this centre and had good

oversight of the residents care needs and supervision of staff.

Judgment: Compliant

Regulation 15: Staffing

Due to a recent change in needs the workforce arrangements in place relied heavily on agency and relief, particularly at night time in this designated centre. However the provider confirmed that there was proposed arrangements to fill these positions. During this inspection staff personnel files were not reviewed regarding the information and documents specified in Schedule 2 of the regulations.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had ensured that there were effective arrangements in place for staff supervision and records were maintained of supervision meetings. Staff team meetings were also being held at regular intervals. Records reviewed indicated that staff were provided with training in areas such as fire safety, safeguarding, managing behaviours that challenge and medicines management.

Judgment: Compliant

Regulation 23: Governance and management

A clear governance structure was in place along with oversight and auditing arrangements, the provider met the requirements regarding six-monthly unannounced visits to the centre and the completion of an annual review. However the provider was not always using audit and review information effectively. Unannounced visits were being carried out but some improvement was required for the supporting action plan and to ensure that the unannounced audit addressed prominent issues relating to the quality and safety of the service provided. Annual reviews were being carried but while the 2017 annual review did refer to some of the pertinent issues related to residents' quality of life and safety, it did not influence action or resources to address these concerns.

Judgment: Not compliant

Regulation 3: Statement of purpose

The inspector found that the service being delivered was not in line with the designated centre's current statement of purpose . The statement of purpose is a key governance document which sets out how the centre is to run and what residents and staff can expect to see in the service. The inspector was not satisfied that the resource arrangements provided to meet the care and supports needs of the residents were adequate.

Additionally the statement required review to in the layout of the floor plans (all parts of the designated centre must be outlined in red, while all overnight accommodation (bedrooms) must be outlined in blue) and one decommissioned bedroom.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge had notified the Office of the Chief Inspector of the occurrence of all notifiable events as required by the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

There were policies and practices were in place relating to complaints. A complaints officer was in place and systems were in place for complaints to recorded and followed up on. There was no open or recent complaints made as viewed by the inspector.

Judgment: Compliant

Quality and safety

Overall the inspector found significant improvements were required to ensure residents were fully supported and in receipt of a safe and quality driven service, these were in the areas of premises, protection against infection and management of medicines. The inspector found good practice in the monitoring of healthcare needs, and safeguarding and protection. It was identified by the inspector that

further improvements were required in resident's personal plans, risk management and fire precautions to ensure they fully complied with regulations.

The suitability of the premises to provide for the current number and profile of residents required review. There were a number of ongoing premises and maintenance issues which were identified in self audits in 2017 which had not yet been addressed by the provider. It was identified by the provider that one house in the designated centre had issues in relation to inadequate living space, insulation issues, inaccessible bathrooms and concerns regarding a steep staircase. Whilst a meeting had been organised with the St John of God housing authority in March 2018 this was cancelled due to bad weather, at the time of inspection no update had been received despite correspondence from management to stress that the property required prioritisation in order to meet the needs of the residents.

The inspector noted that one house in the designated centre, currently a five bedded unit had limited communal space and given residents changing needs and requirements for additional equipment this compounded the difficulties. The overall communal space including the living areas and dining area could not comfortably accommodate the number of residents and required mobility equipment, the provider had identified that the living space was inadequate. The inspector found that one area of the premises did not promote the privacy and dignity of residents, as residents had to access the wet room and shower area through the kitchen due to the inaccessibility of the shower room upstairs. Residents requiring staff support could not access the upstairs shower room as it did not facilitate staff support or level access. An occupational assessment also found that cramped toilet access did not support the safe transfer of residents. Whilst some enhancements had been made to a bath in one of the two bathrooms, following the occupational assessment, this did not result in any long term usage of the bathroom as residents preferred choice and needs indicated the use of shower facilities.

In a quality and safety walk-through of both premises the inspector found both properties required on going maintenance and infection control measures to be implemented. For instance in one bedroom it was noticeably colder than the rest of the rooms and contained an oil burner which was not required in the other rooms. The inspector found that the room was not adequately insulated and there was black mould present. There was no evidence that this issue was raised to maintenance and did not form part of any internal audits or checks. A maintenance log was not maintained and it was unclear who was responsible for carrying out maintenance issues. For example the inspector found peeling kitchen cabinets, peeling paint, a broken shower rail and worn floors, but it was not clear when these shortcomings would be rectified. The inspector identified areas where infection prevention and control measures were not maintained. For example in one property none of the toilet roll dispensers were filled and one bathroom regularly used did not contain any soap. This was immediately brought to attention of the person in charge.

The inspector found residents' well-being and welfare was maintained by a good standard of evidence-based care and support. Care plans and personal support

plans reflected the assessed needs of individual residents and provided detailed guidance to staff to ensure consistent and safe care. Staff spoken with demonstrated a good understanding of the individual needs of the residents. A review of the residents personal plans had occurred in January 2018, this review identified that improvements were needed in the area of goal planning to ensure that residents engaged in meaningful goals which maximised their potential and development. As a result of this review the person in charge had organised individual training for staff to commence. Each resident had comprehensive health assessments in place and were given appropriate support to meet any identified needs. This included appropriate assessments from allied healthcare professionals such as dietitans, occupational therapists and speech and language therapists. There was also evidence that residents were supported to attend National Screening Services as required.

The inspector reviewed fire precautions in the designated centre and found that a fire safety policy and internal emergency response plan were in place. There were fire containment measures in place at key points throughout the building. Service records demonstrated that both the fire alarm system and emergency lighting in place were serviced and maintained on a regular basis, however the provider had not ensured that the annual extended tests were completed, as identified in an internal fire inspection in February 2017. Also there was a delay in addressing reported failures in the emergency lighting system; the same fault was recorded in May, August and November 2018 without corrective action taken place. A review of individual personal emergency evacuation plans in place for residents found that they reflected a recent difficulty experienced during the evacuation of the designated centre during the completion of a fire drill and the implemented measures to manage the risk.

The provider had ensured effective systems were in place to protect residents from any potential abuse. There was evidence that safeguarding concerns were actively addressed in a timely manner and follow through of actions required were implemented and reviewed accordingly. In addition, the inspector found that the person in charge demonstrated comprehensive oversight of behaviours that challenge and safeguarding plans.

The practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines were inadequate and did not protect residents from potential medication errors. For example, the medication policy stated local protocols and procedures for the above practices should be in place, it was found that these were not developed in order to guide staff practice. There was no separate storage for expired medication and inspector observed liquid medication that had been collected from the chemist that day placed beside an opened and expired bottle. When asked how evening staff would know what bottle to dispense from and how expired medication is communicated this could not be explained to the inspector.

Regulation 17: Premises

The registered provider did not ensure that the layout and design in one of the houses met the needs of the residents, nor was kept in good repair. The following was observed during inspection.

- The suitability of the premises to provide for the current number of residents required review as a result of the limited communal space.
- Required alterations to make the centre accessible to all are not carried out.
- There was significant out standing maintenance and repair issues in relation to painting, peeling kitchen cabinets, broken shower rail, mould / ventilation / insulation issues and worn floors.

Judgment: Not compliant

Regulation 27: Protection against infection

The inspector found there was not adequate hand washing / sanitising resources in place to prevent the risk of a healthcare associated infections and environmental cleaning was not implemented.

Judgment: Not compliant

Regulation 28: Fire precautions

The centre had an established fire management system in place,
some improvements were needed in the servicing of fire detection equipment and ensuring faults are fixed in a timely manner.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

It was found that the practices and protocols in place for the ordering, receipt, prescribing, storing, disposal; and administration of medicines was not appropriate.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Overall, the resident's well being and welfare was supported through a good standard of evidence based care and support. There was an established care planning system which incorporated an assessment of needs process from which care plans/interventions were developed, reviewed and evaluated. Improvements were required in the goal planning process to ensure that social and personal care needs were met.

Judgment: Substantially compliant

Regulation 6: Health care

The person in charge had ensured that residents' healthcare needs were assessed on a regular basis and guidance was available to support staff in caring for the healthcare needs of these residents. Residents also had access to a wide variety of healthcare professionals, as required.

Judgment: Compliant

Regulation 8: Protection

Measures to protect residents being harmed or suffering abuse were in place and appropriate action was taken in response to allegations, disclosures or suspected abuse.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for South Clondalkin OSV-0003921

Inspection ID: MON-0023372

Date of inspection: 31/01 and 01/02/2019

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

This document is divided into two sections:

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

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

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 23 (1)(a) A new roster with the additional staff that was put in place has been developed and the vacancies have been recruited and will be in post by the 1st May 2019. 23 (1)(c) Feedback from the HIQA visit was provided to the Quality team who conduct the six-monthly audits on behalf of the Provider. Going forward these audits will also focus on a walk around of the environment and premises. 23 (1)(e) In future Annual Review will clearly state the views and opinions of the residents and their families/representatives.	
Regulation 3: Statement of purpose	Not Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: 03 (1) The Statement of Purpose will be updated to: • Outline exactly what service is provided for the residents • The floor plans will also be updated. • The level of staffing in one location will be updated.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: 17 (1)(a) & 17 (6) (7) The capacity of one house of the Designated Centre has reduced from 6 to 5. A review of the validity of the property going forward will be held with the Housing Authority to ensure the lay out will meet the aims and objectives of the service and the needs of residents.	

From this review a plan of action &/or works will be developed to address the issues of space and accessibility within the property.

17 (1)(b) A plan is being developed with the maintenance team to resolve the following issues:
• Kitchen cabinets to be replaced in one location.
• Paint work to be completed in one location.
• Floors to be replaced in kitchen in one location.
• Shower rail in one location has been fixed.
• Mould in one bedroom has been reviewed and has been addressed.

17 (1)(c) New cleaning schedule has been developed and the PIC now has a more robust system around accountability for staff to ensure work is done. PIC is now also completing more thorough walk arounds. Issues raised re. soap and toilet roll dispensers were resolved on the day of inspection.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Cleaning checklists have been redeveloped with more instruction on exact duties for specific staff on duty. Tasks have also been broken down to daily, weekly and monthly. The Person in Charge is now doing spot checks of cleaning standards also and any issues identified will be emailed to the relevant staff member.

Soap had been available on the day of inspection but was out of view. The soap was returned to the appropriate spot as soon as the inspector noted the soap was not available.

The mould present in one bedroom has been treated and resolved. This has been added onto the monthly cleaning checklist.

Peeling kitchen cabinets, paint work, broken shower rail and worn floors have all been escalated to the maintenance.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: 28 (2)(b)(iii)
A list of work required to address all faults in the fire safety system has been completed by the relevant contractor on the 22/03/19.

New fire extinguishers have been fitted on 20/03/19.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: 29(4)(c) Local procedures were updated on the day of inspection and staff have been inducted on same. Practices have been updated and there are now appropriate systems in place for the ordering, receipt, prescribing, storing, disposal and administration of medication. The medication stock was reviewed and anything that required disposal was returned to the pharmacy and signed for appropriately. There is also a sealed box for medication due to be returned, this is kept on a separate shelf away from regular stock.

Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: 05 (4)(b) Residents goals are being reviewed to ensure they are SMART. The Personal Development Planning Coordinator has been doing 1:1 work with key workers and continues to do so. There are set deadlines and review dates outlined for all goals that the Person in Charge is overseeing.	

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 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	31/08/2019
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	31/08/2019
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	28/03/2019
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Not Compliant	Orange	31/08/2019
Regulation 17(7)	The registered provider shall make provision for the	Not Compliant	Orange	31/08/2019

	matters set out in Schedule 6.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	01/05/2019
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	12/04/2019
Regulation 23(1)(e)	The registered provider shall ensure that that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	30/01/2020
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	30/07/2019
Regulation 28(2)(b)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Yellow	22/03/2019
Regulation 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is	Not Compliant	Orange	20/03/2019

	segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.			
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	20/03/2019
Regulation 05(4)(b)	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 resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	30/07/2019