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:	Centre A1
Name of provider:	Peamount Healthcare
Address of centre:	Co. Dublin
Type of inspection:	Short Notice Announced
Date of inspection:	03 March 2020
Centre ID:	OSV-0005386
Fieldwork ID:	MON-0028692

About the designated centre

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

Centre A1 is a designated centre based on Peamount Healthcare's campus setting in West County Dublin. It consists of five individual units and can support up to 12 adults with intellectual disabilities. It provides 24 hour residential supports to residents and is supported by a staff team which is made up of staff nurses, care assistants, house hold staff, a clinical nurse manager and a person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	11

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
Tuesday 3 March 2020	09:30hrs to 18:15hrs	Thomas Hogan	Lead

What residents told us and what inspectors observed

The inspector met with a number of residents who were availing of the services of the centre and observed care and support interactions. Overall, residents expressed satisfaction with the services they were in receipt of. The inspector observed that residents were supported by staff in a timely manner and that interactions from staff members were kind and respectful.

Capacity and capability

This inspection was carried out as the fourth in a series of inspections to be completed in Peamount Healthcare as part of an escalated regulatory programme in response to failures by the registered provider to comply with the Regulations across a number of campus based centres for persons with disabilities.

Overall, there were high levels of non-compliance identified across the regulations inspected against as part of this inspection. These findings contrasted significantly with those of recent inspections of other designated centres inspected as part of the regulatory improvement plan in place for Peamount Healthcare. The inspector found that this centre was not operated in a manner which ensured that the service provided was safe, consistent or effectively monitored. There were concerns identified in relation to the absence of supports to ensure residents' rights were protected and upheld and in the use of restrictive practices in the centre. Other non-compliances were identified in the areas of staffing, staff training and development, governance and management, complaints management, premises, risk management and fire precautions.

The inspector reviewed the centre's staffing arrangements and found that while there were sufficient numbers of staff employed to meet the assessed needs of residents, there was a high reliance on agency or relief staff members in the centre. For example, in one week reviewed there were 17 agency or relief staff employed to work 21 shifts (252 hours) while on a second week reviewed there were 10 agency or relief staff employed to work 15 shifts (180 hours) in the centre. The inspector found that there was clear evidence of discontinuity of care and support for residents in the centre as a result of these arrangements.

A review of staff duty rosters found that planned and actual rosters were not maintained as required by the regulations. For example, in a number of 'actual' staff rosters, the inspector found that staff members who had been deployed to other designated centres operated by the registered provider during their shift in this centre had not been recorded. In addition, it was unclear who the shift leader was in the absence of the person in charge or clinical nurse manager. Names or full names

of some staff members were not recorded and a number of codes used on the roster documents were not explained.

The inspector reviewed staff training records and found that all permanent staff employed in the centre had completed all mandatory training as outlined by the registered provider. In the case of relief staff, however, records were not made available to the inspector for nine individual relief staff members. In the cases of relief staff members who worked in the centre in the four weeks prior to the inspection and where their records were made available, the inspector found deficits across all mandatory training areas.

A review of staff supervision arrangements found that 47 per cent of permanent staff members employed in the centre were not in receipt of formal one-to-one supervision in line with the organisation's 'staff supervision and development policy' (date 28 November 2019).

The inspector reviewed the arrangements in place for the governance and management of the centre. While there had been a number of recent positive changes at an organisational level, the inspector found that there remained a clear need for the development and implementation of effective management systems in this centre. There was evidence to demonstrate the absence of such systems at the time of the inspection which resulted in a lack of appropriate oversight of the care and support being delivered to residents and a disjointed approach to the management of the centre. For example the registered provider failed to self-identify areas which required urgent attention in the centre. In one case, a 'rights review' had been completed in February 2020 and found that there was little improvement required in this area, however, at the time of the inspection the inspector identified that residents' rights had not been protected or upheld in a number of cases.

The inspector reviewed a sample of incident, accident and near miss records maintained in the centre and found that required notification of incidents to the Chief Inspector had been completed as per the regulations.

A review of complaints management was completed by the inspector and it was found that effective arrangements were not in place in the centre for the management of complaints. For example, no centre based complaints register was maintained and as a result there was confusion amongst the management team as to how many complaints were made in the time since the last inspection. In addition, while reviewing incident and accident data, the inspector found that in one instance a resident wished to make a complaint about the alleged theft of personal belongings, however, no such complaint was recorded in the centre.

Regulation 15: Staffing

There was a significant reliance on agency or relief staff in the centre and as a result of these arrangements there was discontinuity of care and support for residents.

There were a number of improvements required in the maintenance of 'planned' and 'actual' staff duty roster records.

Judgment: Not compliant

Regulation 16: Training and staff development

While the permanent staff team were found to have completed all mandatory training and refresher training, there were considerable deficits in a number of mandatory training areas when the records of relief staff members were reviewed. In addition, records for nine relief staff members were not made available to the inspector. The arrangements in place for the supervision of staff were found not to be satisfactory.

Judgment: Not compliant

Regulation 23: Governance and management

There was an absence of effective management systems to ensure that services provided were safe, appropriate to meet the needs of residents, consistent and effectively monitored.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspector reviewed a sample of incident, accident and near miss records maintained in the centre and found that required notification of incidents to the Chief Inspector had been completed as per the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The inspector found that effective arrangements were not in place in the centre for the management of complaints.

Judgment: Not compliant

Quality and safety

The inspector completed a full walk through of all five units of the centre in the company of the person in charge. Overall, the premises of the centre were found to be in a poor state of repair. A significant number of areas were noted to require painting and decorating and there was damage observed to flooring, doors, door frames, walls, and plaster work in a number of areas. The centre was very institutionalised in nature in a number of its units and did not present in a homely or inviting manner. While the registered provider was making efforts to decentralise services, at least one unit in the centre was observed not to have any laundry facilities at the time of the inspection. The inspector found that the centre was not designed or laid out to meet the aims and objectives of the service or the individual needs of residents. For example, one resident was living in an area of a largely disused building which was not appropriate for long-term use.

A review was completed of the arrangements in place for the preparation of meals in the centre. While there had been efforts to commence the preparation of meals locally in individual units, there remained a significant reliance on the centralised campus kitchens. The level of activity in this area varied amongst the individual units of the centre with some cooking up to four meals locally while in other areas there remained an institutionalised approach to the provision of food and nutrition to residents. In one unit of the centre, the inspector found that the arrangements for the preparation and storage of food items was not appropriate. For example, the kitchen area required significant modernisation and food was found to be stored in an open larder next to a staff toilet on a main corridor.

The inspector reviewed the risk management arrangement which were in place in the centre. While there was a risk register maintained, the inspector found that this did not outline a number of presenting risks such as fire containment, risks associated with behaviours of distress, risks associated with persons with impaired hearing evacuating the centre in the event of a fire and the risks of residents experiencing abuse or neglect. There was clear evidence to demonstrate that there was an absence of effective systems for the assessment, management and ongoing review of risk in the centre. The inspector completed a review of a sample period of incident and accident records for 2019. These records reflected a wide range of incidents, accidents and near miss events and overall, the inspector found that the registered provider had taken appropriate action in response to these. This included a serious incident which occurred in the centre and resulted in the escalation of the matter to the Health Service Executive.

The arrangements for protecting against fire in the centre were reviewed by the inspector. It was found that there were regular fire drills completed which demonstrated that the residents and staff members could evacuate the centre with ease. There was a fire alarm and detection system in place which had been serviced

and maintained on a regular basis. There was emergency lighting fitted to illuminate all exit routes. Personal emergency evacuation plans were in place for each resident which clearly outlined their support needs in the event of a fire or similar emergency. While there were fire containment measures in place in the centre in the form of fire doors and compartments, in a number of cases where there were self-closing devices fitted to fire doors these were observed not to be in working order, disengaged or wedged open.

A review of restrictive practices found that there were significant numbers of restrictions used in the centre. The registered provider was found not to have applied restrictions in line with national policy and evidence based practice. A central register of restrictions maintained in the centre was found not to have logged the majority of restrictions in use at the time of the inspection. Some restrictions which were not identified by the registered provider included the use of observation peep holes in bedroom doors, perspex covers on televisions and stereo systems, a front door locked shut, pad locks on heating systems and fire panels, and locks on a number of internal doors including a sitting room and kitchen/dining room. In all cases, the inspector found that there was an absence of evidence to support the justification for the use of these restrictions. For example, risk assessments had not been completed to highlight the need for control measures or behavioural support plans did not outline the use of these restrictions as necessary for the management of behaviours of concern. The inspector found that the application of restrictive practice formed a key response to behaviours of distress in the centre. This response to such behaviours did not consider the impact of the interventions on the residents affected. Restrictive practices were not used as a last resort after exploring alternative solutions and were not used for the shortest duration necessary.

The inspector spoke to a number of staff members and managers about safeguarding and the protection of residents. All persons spoken with demonstrated satisfactory knowledge of the types of abuse and the actions to take in response to witnessing or suspecting abuse involving a resident. While a number of alleged incidents of a safeguarding nature had occurred in the centre, the inspector found that these had been appropriately followed up on by the registered provider.

A review of how the rights of residents were protected in the centre was completed by the inspector. It was found that the registered provider had failed to ensure that the dignity and privacy of some residents was respected. There was evidence which demonstrated that some residents had not consented to the highly restrictive environment in which they lived as the registered provider had failed to identify a significant number of restrictive practices which were in use. In addition, in the cases of a number of residents, the physical environment was found to be institutionalised in nature and not appropriate to meet their needs. Concerns highlighted by the registered provider regarding the compatibility of residents had not been addressed in a satisfactory manner. At the time of the inspection there was an absence of evidence to indicate that residents availing of the services of the centre had been referred to independent advocacy service for input regarding their human rights.

Regulation 17: Premises

In a number of areas, the inspector found that the premises of the centre were in a poor state of repair. The centre was not homely in nature and presented in an institutionalised manner. The centre was found not to be designed or laid out to meet the aims and objectives of the service or the individual needs of residents. There was an absence of laundry facilities in at least one unit.

Judgment: Not compliant

Regulation 18: Food and nutrition

While the inspector found that efforts had been made in some cases to support residents to purchase, prepare and cook their own meals, this had not been extended to all areas of the centre at the time of this inspection. In addition, the arrangements for the preparation and storage of food items in one unit of the centre was not appropriate.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The registered provider had failed to ensure that there were effective systems in place for the assessment, management and ongoing review of risk in the centre.

Judgment: Not compliant

Regulation 28: Fire precautions

The inspector observed that fire containment measures installed in the centre were compromised in a number of instances.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The use of restrictive practices was not in line with national policy or evidence based practice. There was an overall failure on the part of the registered provider to ensure oversight in this area. A significant number of restrictive practices in use had not been identified as such by the registered provider. Alternative measures were not explored before the use of restrictive practices and they were not applied for the shortest duration necessary.

Judgment: Not compliant

Regulation 8: Protection

The inspector found that the registered provider and the person in charge demonstrated a high level of understanding of the need to ensure the safety of the resident availing of the services of the centre.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector found that the centre was not operated in a manner which appropriately respected the rights of some residents. The registered provider failed to ensure that each resident consented to decisions about their care and support. There was clear evidence to demonstrate that residents had restricted opportunity to exercise choice and control in their lives. The privacy and dignity of some residents was not maintained due to a number of factors including use of restrictive practices, compatibility and the physical environment.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Centre A1 OSV-0005386

Inspection ID: MON-0028692

Date of inspection: 03/03/2020

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1.The provider will ensure that there is a dedicated relief panel available to the centre that are familiar with the residents needs and will provide continuity of care. 2. The Person in Charge will ensure that that the planned and actual roster is checked and approved by the ADONID. 3.The shift leader will be clearly identified on the roster in the absence of the PIC. If there is a change to the staffing in the centre this will be recorded on the roster. The codes used on the roster will be standardized.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1 The mandatory training records for the relief panel will be reviewed. All relief panel will be scheduled for training and this record will be maintained by the centre with support from the HR department. The training tracker will be made available in the centre. 2 The PIC has a plan in place to ensure that all staff receive supervision in line with policy. This will be monitored monthly by the ADONID of the service. 3 The relief staff that are assigned to the centre will also receive their supervision from the PIC.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The person in charge will be provided with education and support from the Quality and Continuous Improvement Department. Key information such as regulatory compliance and social care support are items on the training agenda.

Governance arrangements are in place, and there is a clear reporting structure.The person in charge is supported by the assistant director of nursing, who will continue to support and coach the person in charge in their role. Increased oversight will take place by the assistant director of nursing which will include:

- Qualityand safety walkarounds by the person in charge
- Audit management
- Daily handovers

Weekly walkabouts with representation from the senior management team to ensure oversight of quality and safety. This is currently on hold and will commence when safe to so.

The person in charge continues to maintain a supervision log and support staff with their supervision in line with policy on a scheduled basis.

There is a peer audit schedule in place that supports key audit activities such as resident rights, restraint practices and medication management practices. All findings are recorded on a quality improvement action plan, the person in charge has oversight of the action plan.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The PIC has put in place a complaints register which will be maintained by the staff in the centre.
The ADONID and the PIC will complete education with all staff in the centre on the importance of logging all complaints.
The person in charge is aware of the process to escalate any complaints to the designated complaints officer that cannot be addressed locally. The person in charge has access and has read the complaints policy and procedure. This procedure is available for

all staff in the centre to read.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• A redecoration plan was due to commence in the centre to ensure that it is more homely and inviting for the residents, unfortunately this has been put on hold during the current crisis.
• Residents will be consulted on the colours and the modernization plan.
• The kitchen and dining area will be modernized as part of the plan.
• The doors in the centre will be refurbished.
• The office for the center will be relocated to an alternative location on the campus. Residents will provide feedback on what they would like to use the vacant room for.
• A plan has been submitted to the HSE for the construction of a seomra to meet the needs of a resident in St Kevin's unit. We await confirmation of the funding.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
• The Person in charge will continue to support staff in the role out of the preparation of meals in the centre.
• A support team has been put in place.
• Staff have received training in food hygiene.
• The storage of food in the centre will be addressed as part of the modernization of the kitchen and dining area.
• Staff will support residents in menu planning, in preparing shopping lists and in the purchase of food. This will be rolled out in all areas.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

The registered provider will ensure that all risks will be identified, assessed and managed in the centre in line with the centres risk management policy, as set out in Schedule 5.

a. hazard identification and assessment of risks throughout the designated centre through reviewing the centres local risk register
b. measures and actions will be in place to control the risks identified and,
c. measures and actions will be in place to control the following risks:

- accidental injury to residents,
- visitors or/and staff
- aggression and violence
- self-harm
- Individualised resident risks such as impaired hearing
- fire safety
- restraint practice in the centre and its associated risks

All risks will be reviewed as required, and as an ongoing agenda item and at the centers management team meeting.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The fire doors have been reviewed by maintenance and the self-closing devices are now in working order.
• Staff have been educated on the importance of ensuring that fire doors are not wedged open. This will be monitored by the PIC and the ADONID.
• The PIC has introduced a daily checking system in the centre to ensure that fire doors are not wedged open and self- closing devices are in working order.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• All residents' behavior support plans will be reviewed. Where a restrictive practice is identified as a method of behaviour management this will be reviewed by the MDT in consultation with the resident and an alternative approach will be explored.
• Where the resident has requested that this restriction remains in place this will be documented in the residents positive behaviour support plan and the rationale for

keeping the restriction in place. This will be reviewed at the MDT and in consultation with the resident on a monthly basis at the individualized resident support meeting.
• All restrictions will be documented and monitored through the person in charge and will demonstrate active awareness on restraint reduction and on promoting individualised residents rights. Open restraints will be escalated and reviewed at the positive behavioural support steering group.
• Environmental restrictions will be recorded on the restraint register log and reviewed on a monthly basis. Rational for its use, demonstrations for active reduction of restraint and escalation of risk will be monitored.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The residents will be introduced to representatives from the national advocacy service and if the resident chooses they will have the opportunity to receive their support on an individualized basis. This will be addressed following the lifting of restrictions.
• A review of all restraint practices and identification will be carried out as per the centers policy on restraint reduction and management. A self-assessment on restraint practices will be carried out and actions implemented. The national advocacy service has agreed to review the restraint practices within the center in line with resident rights.
• Through the transfer committee issues or concerns regarding compatibility of residents living in the centre will be addressed. Residents will have the opportunity to raise concerns about their living arrangements with their key worker who will be supported by the CNM1 and PIC and forwarded to the transfer committee for consideration.
• A redecoration plan was planned to commence in the centre to ensure that it is more homely and inviting for the residents. Residents will be consulted with and will participate in the recordation of their home, this area will be added as an ongoing item to the agenda for their house meetings.
• The redecoration of their home will address the privacy and dignity of each individual and will support their rights throughout.

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(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	30/06/2020
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Not Compliant	Orange	30/03/2020
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	Not Compliant	Red	30/06/2020

	development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/06/2020
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	30/09/2020
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	Red	30/09/2020
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	30/09/2020
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	30/09/2020
Regulation 18(1)(a)	The person in charge shall, so far as reasonable and practicable, ensure that residents are supported to buy, prepare and cook	Substantially Compliant	Yellow	30/06/2020

	their own meals if they so wish.			
Regulation 18(1)(b)	The person in charge shall, so far as reasonable and practicable, ensure that there is adequate provision for residents to store food in hygienic conditions.	Substantially Compliant	Yellow	31/08/2020
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 to residents' needs, consistent and effectively monitored.	Not Compliant	Red	31/05/2020
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	31/05/2020
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/03/2020
Regulation 34(1)(c)	The registered provider shall	Not Compliant	Orange	31/03/2020

	provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall ensure the resident has access to advocacy services for the purposes of making a complaint.			
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	30/03/2020
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Not Compliant	Orange	30/03/2020
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or	Not Compliant	Orange	30/09/2020

	her representative, and are reviewed as part of the personal planning process.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Red	31/05/2020
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	30/07/2020
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Red	31/05/2020
Regulation 09(1)	The registered provider shall ensure that the designated centre	Not Compliant	Orange	31/05/2020

	is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Red	31/05/2020
Regulation 09(2)(d)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has access to advocacy services and information about his or her rights.	Not Compliant	Orange	31/05/2020
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	Not Compliant	Red	31/05/2020

	communications, relationships, intimate and personal care, professional consultations and personal information.			