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:	Aspire Residential Unit
Name of provider:	Autism Spectrum Association Of Ireland Company Limited By Guarantee
Address of centre:	Dublin 16
Type of inspection:	Announced
Date of inspection:	02 October 2024
Centre ID:	OSV-0001530
Fieldwork ID:	MON-0036278

About the designated centre

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

Aspire residential service is described by the provider as providing a residential service for up to three autistic adults in a suburb of Dublin city. The house is located within walking distance of a number of amenities such as shopping centres, a library, restaurants and parks and has good public transport services. The house is a four bedroom house. Downstairs there are two living rooms, a kitchen, a bathroom and a porch which serves as a conservatory. Upstairs there are two offices, a staff sleep over room and three bedrooms, each of which has an en-suite bathroom. There are gardens to the front and the rear of the property. The aim of the service is to provide a high level of individualised support to residents to enable them to develop their independent living skills, engage with the community and fulfil their personal goals in a caring and safe environment. The centre is staffed on a 24 hour basis including sleepover staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 2 October 2024	10:30hrs to 18:15hrs	Julie Pryce	Lead

What residents told us and what inspectors observed

This inspection was conducted in order to monitor on-going compliance with the regulations, and to inform the registration renewal decision.

There were two residents on the day of the inspection, and both had been informed by the person in charge that an inspection was to take place. One of the residents had been anxious about the visit, and had decided to go out in the morning. They were very independent, and were supported by staff to make their own decisions in many ways, including whether or not to meet the inspector. They had the key to their own room, and had locked it in advance of the inspection, and the inspector respected this decision and did not enter their room.

However, they returned later in the day and agreed to have a chat with the inspector. They said that they were happy in their home and that they felt supported by staff, and that they enjoyed their living arrangements with the other resident. They spoke about various activities that they enjoyed independently, and that they knew that staff were there to support them.

They explained that they were supported in their independence, and spoke about going out for days on their own and knowing who to contact if they needed any support. The inspector asked them who they would go to if they had any concerns, and they named the staff members who would support them. They spoke about a minor complaint that they had brought to the attention of staff, and explained that the issue had been resolved.

They were very aware of safety issues, including fire safety and safeguarding, and mentioned that they did not like change, and were concerned that there were plans to change the person in charge, but that they were being supported by staff in this matter. The inspector spoke to the person in charge about this matter, and it was clear that they were being supported in advance of the change.

The other resident did not always choose to communicate verbally, and while they met the inspector briefly, did not choose to speak to them. The inspector asked if they were happy, and the resident gave a definite 'thumbs up' to the question, and again when asked if they felt safe in their home.

In the absence of any further communication from the resident, the inspector reviewed documentation relating to the elicitation of the views of residents, from the six-monthly unannounced visits on behalf of the inspector, and from surveys completed by residents in advance of the inspection.

Comments in the surveys included: 'I have it brilliantly in this home' and 'My housemate is a gentleman'. Another comment read: 'Wonderful place to live'. There were also comments from the families of residents, and one comment from a family

member said that their relative appreciates the atmosphere in the house.

Further opinions were sought from residents in relation to the person centred planning process, and one of the residents had said 'I have a chance to express myself'.

The inspector conducted a 'walk around' of the designated centre, whilst respecting the preferences of residents, neither of whom invited the inspector into their personal bedrooms. The communal areas were well maintained and nicely decorated, with personal pictures chosen by the residents evident throughout. The kitchen area included an island with bar stools, and staff explained that the residents would sit in this area during meal preparation, and would participate sometimes. There were several communal areas, and one of them contained sensory items that were preferred by one of the residents.

There were spacious outside areas, and as one of these areas was to the front of the house, there were tall privacy trees, and the area was private from passers-by. There was garden furniture, and a pleasant sitting area had been developed.

Overall it was clear that residents were supported to have a meaningful life, and to be supported in their independence. Significant improvements were required in the management of medication, and in policy development, and some improvements were required in care planning, but the inspector was assured that residents' rights were upheld, and that they were held at the centre of operation of the designated centre.

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

Capacity and capability

There was a clearly defined management structure in place, and lines of accountability were clear. There were various oversight strategies which were found to be effective in the most part, with some improvements required in consistency and documentation. While most of the required policies were in place, there were some gaps that required attention.

There was an appropriately qualified and experienced person in charge who was involved in the oversight of the centre and the supervision of staff.

There was a competent staff team who were in receipt of relevant training, and demonstrated good knowledge of the support needs of residents, although staff support for residents on outings remained challenging to the provider.

All the required notifications had been submitted to HIQA within the expected

timeframes.

Regulation 14: Persons in charge

The person in charge was appropriately skilled and experienced, and was involved in the oversight of the centre. It was clear that they were well known to the residents, and that they had an in-depth knowledge of the support needs of each resident.

Judgment: Compliant

Regulation 15: Staffing

There was a consistent staff team who were known to the residents. A planned and actual staffing roster was maintained as required by the regulations. However, where there was a requirement for one of the residents to have a 2:1 staff support when out in the community, this was not always available. The provider had submitted a business plan to the funding organisation in relation to this matter, but at the time of the inspection this had not been resolved. There were occasions where the resident was supported either by the person in charge or the person participating in management in order to access the community, which meant that they were absent from their prescribed duties.

The inspector reviewed three staff files and found that they contained all the information required by the regulations, including current garda vetting.

The inspector spoke to the person in charge and a member of staff and found them to be knowledgeable about the care and support needs of residents, and about the management of any identified risks in the centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

All staff training was up to date and included training in fire safety, safeguarding, and human rights. Additional training had been undertaken in relation to the specific support needs of residents including the support of people with autism, dysphagia and advocacy.

There was a schedule of supervision conversations maintained by the person in charge, and these conversations took place every 8-12 weeks. The inspector viewed these records, and saw that there was a review of personal developments, a

discussion of any issues raised, and a record of positive feedback about aspects of each staff member's practice. They also included a review of any agreed actions from the previous conversation.

Judgment: Compliant

Regulation 23: Governance and management

There was a clear management structure in place, and all staff were aware of this structure and their reporting relationships.

Various monitoring and oversight systems were in place. Six-monthly unannounced visits on behalf of the provider had taken place, although there was a visit due in February 2024 which had not taken place. An annual review of the care and support of residents had been prepared in accordance with the regulations. The annual review was a detailed report of the care and support offered to residents, and it identified areas for improvement.

However, the timescales for any identified actions were vague, for example some of the timescales were identified as being '2024' and for some actions not identified at all, so that it was unclear as to the expected timeframe.

Audits had taken place, for example, audits of fire safety, restrictive practices, keyworking and medication management. As further discussed under regulation 29, the medication audit did not identify the failings found during this inspection.

Staff team meetings were held, although the timing of them was not consistent, in that there were six meetings held in 2023, but in 2024 meetings had only been held in January and August. A record was kept of the discussions in these meetings which included risk assessments, residents' goals and activities and family contact.

Daily communication with staff was well managed via a verbal and written handover at the change of each shift, and a system of regular e-mailing.

All the required actions form the previous inspection had been implemented, although further improvements were required in medication management, as discussed under regulation 29.

Overall, staff were appropriately supervised, and the person in charge and senior management had good oversight of the centre, although improvements were required in consistency and documentation.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

All the required notifications had been submitted to HIQA, including notifications of any incidents of concern.

Judgment: Compliant

Regulation 4: Written policies and procedures

Most of the policies were in place in accordance with Schedule 5 of the regulations, however the following policies were not in place:

Incidents where a resident goes missing.
Provision of information to residents.
Access to education, training and development.
It was particularly relevant the policy relating to 'Incidents where a resident goes missing' was not in place as this was an identified risk for one of the residents.

In addition, the policy on Medication management did not contain sufficient detail, as further discussed under reg 29.

Judgment: Not compliant

Quality and safety

There were systems in place to ensure that residents were supported to have a comfortable life, and to have their needs met. There was an effective personal planning system in place, and residents were supported to engage in multiple different activities.

The residents were observed to be offered care and support in accordance with their assessed needs, and staff communicated effectively with them.

Healthcare was effectively monitored and managed and changing needs were responded to in a timely manner.

Fire safety equipment and practices were in place to ensure the protection of residents from the risks associated with fire, and there was evidence that the residents could be evacuated in a timely manner in the event of an emergency.

There were risk management strategies in place, although not all identified risks had

effective management plans in place.

Significant improvements were required in the management of medication, particularly in ensuring the competence of the staff team.

The rights of the residents were well supported, and residents indicated that they were happy in their home. Staff were knowledgeable about the support needs of residents and supported them in a caring and respectful manner.

Regulation 26: Risk management procedures

Risk registers were maintained which included both local and environmental risks, and individual risks to residents. There was a risk assessment and risk management plan for each of the identified risks. The risk assessments identified the initial risk and the residual risk following control measures.

Individual risk assessments included the risks relating to fire safety, choking and the risk of absconding, which was identified as being a high risk for one of the residents. There was a detailed management plan in place for each of the identified risks, and staff were familiar with their role in implementing the risk management plans.

However, there was no risk management plan in place regarding low staff numbers, which was an identified risk as discussed under regulation 15, or in relation to lone working, so that there was no plan in place to identify and respond to any issues that might arise should a staff member find themselves in difficulties.

There was a current risk management policy in place, however it did not include all the requirements of the regulations.

The inspector was assured that control measures were in place to mitigate any identified risks relating to individual residents in the designated centre, improvements were required in the management of local risks and in the risk management policy.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had put in place structures and processes to ensure fire safety. There were self-closing fire doors throughout the centre and all equipment had been maintained. Regular fire drills had been undertaken, and there was an up-to-date personal evacuation plan in place for each resident, giving clear guidance to staff as to how to support each resident to evacuate and all staff had received training in

fire safety.

Staff accurately described the ways in which to support each resident to evacuate in the eventuality of an emergency, in accordance with the information in the Personal evacuation plans and the resident who spoke to the inspector knew how to respond to an emergency.

These discussions and the documentation in relation to fire safety indicated that residents were protected from the risks associated with fire, and that they could be evacuated in a timely manner in the event of an emergency.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

While there was evidence of some good practice in relation to medication management, significant improvements were required to ensure compliance with the regulations.

Staff explained very clearly the steps that they took when administering medication, and these steps were in accordance with best practice. The inspector checked the records of administration and found them to be correct.

Medications were supplied by the pharmacist in accordance with the current prescriptions, and staff checked the supply of medications when they were collected.

One of the residents had previously been supported to self-administer medications, but had found that it did not suit them, and so had requested staff support. This resident, who had spoken to the inspector, said that this was their own choice.

However, when staff were asked about the purpose of a sample of prescribed medications, they did not know what they were all for. In addition, while some improvements had been made since the previous inspection in relation to the assessment of competence of staff, the practice was not in accordance with best practice.

While all staff had completed an on-line course in the safe administration of administration of medication, the competency assessments were conducted by personnel who did not have any accredited training in this area.

The inspector reviewed two 'as required' medications and found that there were no protocols in place to guide staff as to the circumstances under which they should administer these medications.

There was a policy in place in relation to medication management, however the policy did not include sufficient detail, for example, it referred to a requirement for three competency based assessments for each staff member, but did not outline the

requirements of the assessor.

The inspector reviewed the stock control of loose medications and found multiple errors, so that it was not possible to determine whether or not the current stock was correct.

Audits of medication management had been undertaken on a quarterly basis, and the required actions identified in these audits had been implemented, for example an oversupply of medication of PRN medications had been identified and rectified, the need for hand sanitiser to be available had been actioned, and a medication fridge had been put in place. However, the findings of this inspection had not been identified.

The inspector was therefore not assured that medication practices were safe overall, or that there was effective oversight in this area.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

There were personal plans in place for each resident, based on a detailed assessment of need which was reviewed at least annually. A person-centred plan had been developed with each resident, and person centred planning meetings were held regularly at which goals were set or reviewed with each resident in relation to maximising their potential. Goals were set in accordance with the preferences and abilities of residents, and steps towards achieving goals were recorded regularly.

There was an emphasis on gaining and maintaining independence for residents, and on listening to their views. For example, where a resident had chosen to discontinue a goal and focus on another area, this was respected and documented.

There were regular meetings with residents in relation to their person centred plans, and all the information was available to residents in an accessible format.

The personal plans included sections on healthcare and where some of the detail related by staff in relation to one issue for a resident was not clear in the plans, they undertook to update the plan following the inspection. Overall it was evident that residents were supported in all aspects of their care and support.

Judgment: Compliant

Regulation 6: Health care

Healthcare was well managed, and both long term conditions and changing needs

were responded to appropriately. There were detailed healthcare plans in place, for example in relation to epilepsy, asthma and modified diets. There was evidence that these care plans were implemented, and staff spoke about their role in healthcare in detail.

Residents had access to various members of the multi-disciplinary team (MDT) as required, including the occupational therapist, the speech and language therapist and the physiotherapist.

There was a 'health passport' in place for each resident which gave an overview of all their healthcare needs, and evidence of the involvement of residents in their healthcare plans.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where restrictive practices were in place they were the least restrictive available to mitigate the identified risks, and where a restriction applied to one of the residents, the other resident was not restricted. For example, the kitchen was locked at times ot mitigate the risk of choking for one of the residents if they had unsupervised access, the other resident had their own key and had free access.

Consent had been sought from residents in relation to restrictions, and information in an easy-read format had been made available to assist in their decision making. Consent forms had been signed by residents so that it was clear that there was full transparency in relation to any restrictions.

A register was maintained which included information about each restriction, and this register included a clear rationale for each intervention.

However, staff had not received training in the management of behaviour that is challenging including de-escalation and intervention techniques as required by the regulations.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents were consulted with regularly about the operation of the designated centre, and about their care and support needs.

Regular residents' meetings were held, and residents chose whether or not to attend these meetings. If they chose not to attend staff ensured that individual discussions

were held with them. Staff ensured that the voices of residents were heard and that they were supported to make their own decisions. Where residents might make unwise decisions, staff described the ways in which they would ensure that all pertinent information was made available to them. For example, where one of the residents who had been identified as having trouble sleeping chose to have coffee late at night, staff explained the effect that this might have, but ultimately respected the resident's choice.

Staff were very familiar with the ways in which residents chose to communicate, for example one of the residents often chose not to communicate verbally, but would use a series of non-verbal gestures, such as the thumbs up or down they used with the inspector.

One of the residents, while independent in managing their own money for the most part, had asked for help from staff in saving for a trip, and this had been facilitated as they requested. The resident explained to the inspector that they had requested this support.

There were examples of staff having advocated on behalf of residents, for example where one of the residents disliked video meetings with one of their healthcare professionals, staff had arranged face-to-face meetings.

Overall it was evident that all efforts were made to ensure that the rights of residents were respected.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Aspire Residential Unit OSV-0001530

Inspection ID: MON-0036278

Date of inspection: 02/10/2024

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: In response to the concern raised regarding the availability of 2:1 staff support for one of our residents when accessing the community, we would like to inform you of the following actions we have taken: We have submitted a comprehensive business plan to our funding organization outlining the need for additional resources to ensure consistent 2:1 staffing support for the affected resident. We are actively following up on this submission and are in discussions with our funders to expedite a resolution. We have explored and will continue to explore temporary staffing options to ensure that the resident receives the necessary support when in the community. This includes utilizing additional staff from within the residential and may include engaging qualified agency staff as needed.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: We will ensure that these visits are conducted as scheduled moving forward. Our next 6 monthly unannounced in due in February 2025, a second is scheduled for August 2025 and the annual review will be completed in December 2025. We are committed to making our action plans more specific and will ensure that all future reviews include clear and measurable timelines for implementation. We recognize the need for more effective audits, particularly in the area of medication management. We are implementing a more rigorous review process to ensure that all potential failings are identified and addressed promptly. We have already made a number of significant improvements on our medication documents, including the update	

of our medication audit, Kardex and MARS. We have enlisted the services of Slainte Healthcare in our medication management.
In relation to the inconsistency in the timing of staff team meetings, we have established a schedule to ensure that these meetings occur more frequently throughout the year. Our next staff meeting will be held on the 11.12.24.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

We are in the process of developing and implementing policies on incidents where a resident goes missing, provision of information to residents, access to education and training, and updating our medication management policy. We will ensure they align with best practices and regulatory requirements of schedule 5.

Regulation 26: Risk management procedures	Substantially Compliant

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

Regarding our management of local risks, particularly in relation to low staff numbers and lone working, we are implementing the following actions:

We will conduct a comprehensive risk assessment regarding low staff numbers and lone working scenarios. Following the risk assessment, we will develop clear risk management plans that will explicitly address low staffing levels and lone working challenges. We have already taken action in mitigating risks such as new evening communications to ensure staff and resident safety.

We have updated our risk management policy to ensure it aligns with all regulatory requirements in schedule 5.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

We acknowledge that improvements are required in areas highlighted in the report. Actions include:
We have reviewed our competency assessment procedures and have enlisted the services of a qualified Nurse to carry out competency assessments going forward.
We have developed and implemented clear protocols for all 'as required' medications to guide staff in their administration, these have been signed off by their Doctors. Every individual receiving care has a personalized plan outlining when and how these medications should be used.

Our medication management policy has been updated to include detailed requirements for competency assessments, outlining the specific qualifications and training needed for assessors. A thorough audit has taken place to ensure accurate stock records are updated and maintained, and we will introduce additional steps to enhance oversight. Beyond the online training currently in place, we have implemented in-person training (08.11.24) for our staff focused on medication management and safety, along with regular monitoring to ensure compliance.

Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: We recognize the gap in our staff training regarding the management of behavior that is challenging, particularly in the areas of de-escalation and intervention techniques. We have scheduled in person training for all staff the in Prevention and Management of Violence and Aggression Behaviour, which will take place on the 11.12.24.	

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(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	30/12/2024
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	28/02/2025
Regulation 23(3)(a)	The registered provider shall ensure that	Substantially Compliant	Yellow	31/12/2024

	effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.			
Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: self-harm.	Substantially Compliant	Yellow	12/11/2024
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.	Substantially Compliant	Yellow	31/12/2024
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate	Not Compliant	Orange	28/02/2025

	and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.			
Regulation 04(1)	The registered provider shall prepare in writing and adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	31/03/2025
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	12/12/2024