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:	Blossomville
Name of provider:	St Joseph's Foundation
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	03 October 2024
Centre ID:	OSV-0001822
Fieldwork ID:	MON-0043819

About the designated centre

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

Blossomville is a purpose built single storey bungalow located in a town. The centre comprises of six bedrooms, two sitting rooms, a kitchen-dining room, a utility room, a staff office and bathroom facilities. The centre has a maximum capacity of six residents and can provide full-time residential care to residents with intellectual disabilities and /or autism who present with behaviour that challenges and additional needs. Both male and female residents over the age of eighteen years can reside in the centre. The staff team comprises of a person in charge, social care workers, nurses and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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
Thursday 3 October 2024	06:55hrs to 14:55hrs	Conor Dennehy	Lead
Friday 4 October 2024	09:55hrs to 17:55hrs	Conor Dennehy	Lead
Thursday 3 October 2024	06:55hrs to 14:55hrs	Deirdre Duggan	Support
Friday 4 October 2024	09:55hrs to 17:55hrs	Deirdre Duggan	Support

What residents told us and what inspectors observed

This inspection was conducted over two days during which all residents present were met. All residents left the centre at least once during the course of the inspection. The atmosphere in the centre was generally calm but vocalisations from one resident were occasionally heard.

Six residents were living in this centre with the current inspection conducted over the course of two days. All six residents were met during the inspection although most did not interact verbally with inspectors so inspectors could not get all residents' direct views on what it was like to live in the centre. As result, to get a better sense on what life was like in the centre, inspectors also spent time reviewing documentation, observing interactions and speaking with staff and a member of the centre's management. To meet as many staff as possible, the first day of the inspection was started at an earlier time in order to meet some night staff before they went off shift.

The atmosphere in the centre across both days was generally calm although at one stage during one of the inspection days, a staff member was heard expressing frustration in communal areas with residents present. In addition, at times throughout both days of inspection one resident became heightened occasionally which resulted in the resident becoming vocal or banging surfaces. At such times staff and management present sought to support the resident. On one occasion, it was observed that two residents present had to be redirected from a communal room due to the resident's presentation. On another occasion a resident commented when the relevant resident knocked over a sign. Such matters will be returned to later in this report.

Some of the residents met did not meaningfully interact with inspectors or did not respond to the inspectors when greeted by them. At one point an inspector asked if he could sit in one of the sitting rooms with a resident but the resident indicated no. The resident's choice in this was respected. Another resident took an interest in one of the inspectors and spent time with them in the centre across both days. This resident also showed both inspectors a scrapbook they had which contained photographs of the resident doing things such as celebrating their birthday. A third resident indicated that they liked living in the centre and also spoke about their family, and about a visit home that took place on the first day of the inspection. Generally, residents seemed content during the inspection.

Across both days of the inspection, all six residents left the centre at least once although two residents appeared to spend much of their time in separate sitting rooms. One of these residents was overheard being asked if they wanted to leave the centre at times but declined most of these. Another resident also spent time sitting in the staff office, particularly during the first day of inspection, looking out of the window there. It was indicated that this was something which the resident liked to do. In the afternoon of both days of inspection, inspectors were asked to

temporarily leave the centre in order to encourage this resident to go on outings. Inspectors agreed to such requests.

On the first day of inspection, this resident left the centre shortly after inspectors temporarily departed. On the second day the resident had not left when inspectors returned but did leave the centre shortly after this to go for a drive with another resident. Generally, across both days residents were brought from the centre to do things like meet relatives, do shopping, go swimming and horse riding although on the first day, it was highlighted that a planned activity to go to the cinema could not proceed due to staffing levels being lower than intended. The centre had one vehicle generally during the weekdays for activities. All six residents could not travel together on this vehicle but the centre was able to access a second vehicle from the provider's day services at other times.

Each resident in the centre had their own bedroom. Shortly after arriving in the centre on the first day of inspection, it was observed that the door to one resident's bedroom was open with the resident sill in bed. An inspector was informed that this was to monitor the resident for possible seizures and that this was what the resident wanted. Reference to this was also contained within the resident's personal plan. Later on during the first day of inspection, it was seen that a resident's mattress had no bed linen on it and the mattress itself was visibly unclean. While it was indicated that the resident could tear their bed linen, it was not clear if the resident was offered bed linen each night. This was highlighted to management of the centre during the first day of inspection.

On the morning of the second day, inspectors were informed that bed linen had been put on the resident's bed overnight which was seen to remain on the bed throughout the second day. The issue of the unclean mattress will be returned to later in this report. Aside from this mattress, the remainder of the centre was reasonably clean and furnished while, since the previous inspection, part of the rear garden/patio had been made sheltered. A trampoline was also located in the rear area of the centre which a resident was seen to use. At the time of the April 2024 inspection of this centre, consideration was being given to making an external garage area into an extra space for residents but this had not progressed.

Within the centre itself, some signs and posters were on display. These included posters highlighting the identities of the provider's complaints officer and designated officer (person who reviews safeguarding concerns). In the kitchen area there was also a noticeboard with posters highlighting some key information related to residents' nutrition. The kitchen had facilities to store food hygienically in including presses and a large fridge-freezer. Given the needs of one particular resident, certain food item were not kept in the centre with grocery shopping done regularly. When viewing the food storage during the second day of inspection, various food items were seen to be present in the centre. Meals were seen to be prepared in the centre on both days of the inspection.

In summary, while the centre was generally clean, at the time of the inspection one resident was sleeping on a mattress that was visibly unclean. All residents living in the centre were met but some did not interact significantly with the inspectors.

Generally such residents seemed content. All residents did leave the centre at some point during the inspection.

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 on the quality and safety of the service being delivered.

Capacity and capability

Regulatory actions were identified across all regulations reviewed on this inspection. This included areas such as staffing, the provision of supervision, safeguarding and records.

This centre was registered until December 2026. However, inspections conducted on behalf of the Chief Inspector of Social Services in January 2024 and April 2024 had raised concerns around the supports provided to residents, governance, safeguarding and staffing issues amongst others. Both of those inspections had been prompted by information of concern or safeguarding notifications received by the Chief Inspector. Given the nature of the issues identified on those inspections, the fitness of the provider had been formally assessed in April 2024 with a letter of concern subsequently issued that raised concerns around the governance arrangements for the centre. The provider submitted a response to this which outlined new overall governance structures that they had since implemented.

However, during September 2024 there was a notable increase in notifications of a safeguarding nature submitted by the provider from this centre. In addition, further information of concern was received by the Chief Inspector. The nature of some of this information prompted the Chief Inspector to seek immediate assurances from the provider during September 2024 related to healthcare, medicines management and nutritional supports for residents. The provider subsequently submitted a provider assurance report (PAR) response indicating that no quality improvement was needed regarding healthcare and nutrition but did highlight that there was some needed regarding aspects of medicines management.

While this PAR response and supporting documentation provided was noted, given the recent regulatory history of the centre along with the notifications and information of concern received, the decision was made to conduct the current inspection to review specific lines of inquiry. Overall, the inspection found regulatory actions across all regulations reviewed. Notable matters in this regard relating to the continuity of staff support, the cleanliness of one resident's mattress, concerns around resident compatibility and medicines management. While there had been some management changes since the April 2024 inspection, some of which were acknowledged to be recent developments, varying information was provided to inspectors relating to management support. It was also identified that staff had not

been in receipt of formal supervision during 2024.

Improvement was also identified as being required relating to the documentation as outlined under Regulation 21 Records. Other documents reviewed included body maps which are intended to record any injuries such as bruises and marks noted on residents. Inspectors were informed that there was no specific protocol related to body mapping but that body maps completed were to be signed by two staff members. When reviewing body maps in recent months, an inspector noted that this was generally done but not always. A recent incident report made reference to there being two inaccurate body maps previously although when queried with a member of management it was indicated that there had only been concern raised around the accuracy of one. When inspectors requested to review this body map, it could not be located. The same recent incident report also referenced a resident having a mark on their body. No body map for this mark was provided during the inspection although it was indicated that the mark could relate to skin issues for the resident.

Regulation 15: Staffing

Staffing in a designated centre must be in keeping with the needs of residents and the centre's statement of purpose. The statement of purpose for the centre had been reviewed in October 2024 and indicated that there was a total of 16 whole-time equivalent (WTE) staff assigned to the centre to provide front-line support to residents. This WTE was to be comprised of nurses, social care workers and care staff and from such front-line staff there was to be five staff on duty by day and three by night. Despite this, discussion with staff and rotas reviewed indicated that there were times when such staff levels were not in place.

This included during the first day of this inspection. It was indicated that staffing being reduced could impact planned activities for residents which happened on the first day of inspection as a planned cinema trip could not proceed. It was also evident from the staff rotas reviewed that a high number of different individual staff had worked in the centre in recent times relative to the centre's assigned WTE. In particular, from 29 July 2024 up until the second day of inspection, over 50 different individual staff had worked in the centre. Some of these staff were agency staff (staff sourced from an agency external to the provider), some of whom worked just one shift in the centre.

It was highlighted to inspectors that the centre did have some vacancies and had made efforts to obtain regular agency staff where possible. It was also acknowledged that there was staffing challenges in the health and social care sector generally. However, given the high number of different staff that had worked in the centre in recent times, the provider had not ensured that residents had received a continuity of staff support. Such continuity promotes consistency of care and professional relationships with familiarity of staff highlighted as being important to the needs of the residents living in this centre. In addition, it was indicated to the inspectors that the use of agency staff working in the centre contributed to some of

the actions found on this inspection such as gaps in certain records and medicines errors. Reference was also made during this inspection to there being some communication issues between staff in the centre.

Judgment: Not compliant

Regulation 21: Records

Under this regulation, the provider must maintain specific documentation and make these available for inspection to the Chief Inspector. This includes documentation relating to all staff working in a centre, including agency staff. Given the use of agency staff in this centre, documentation relating to such agency staff was requested during this inspection. This documentation was provided with an inspector reviewing three agency staff files. These were found to contain all of the required information such as proof of identification, employment histories and evidence of Garda Síochána (police) vetting. This was an improvement from previous inspections in March 2023 and April 2024.

While this was a positive, this regulation also requires records of food provided to residents to be maintained in sufficient detail to determine if residents' diets are satisfactory in relation to their nutrition. All residents had menu plans in place which outlined what food and drink residents were to receive to meet their dietary needs. The same menu plans also had a space to record what food and drink residents had. Inspectors reviewed a sample of these records for two residents and it was noted that these records contained limited detail as what residents had for particular meals. For example, according to their menu plan, one resident was to have a cereal, some fruit and a drink for their breakfast but the only entry that was recorded for the resident for that meal was "supplements tea". As such, these records did not indicate if residents received appropriate nutrition or not while the records also did not indicate if residents were offered food and/or refused such food.

Aside from food, records must be kept of any occasion when a restrictive practice is used in respect of a resident and how long it is used for. Within the centre there was an approved restrictive practice that the door to the staff office would be locked when unsupervised or during particular meetings. Inspectors were informed though that records were not being kept of when this restriction was used and how often it was used for. The locking of the staff office door is discussed further under Regulation 7 Positive behavioural support.

Judgment: Substantially compliant

Regulation 23: Governance and management

The two earlier inspections of this centre in 2024 had raised concerns around the overall governance of this centre including the absence of a dedicated on-site person in charge for the centre. In the time leading up to the current inspection the provider had notified the Chief of Inspector of the appointment of a new person in charge.

Given the previous findings of the earlier 2024 inspections, the support from and presence of centre management generally was queried with staff members during the current inspection. Inspectors received varying responses to these areas from staff. For example, some staff indicated that there was a regular management presence in the centre while others said that there was not. A member of management spoken with during this inspection indicated that they were regularly present in the centre prior to the appointment of the new person in charge. A visitors' log of the centre indicated that members of the provider's senior and executive management had visited the centre since the April 2024 inspection.

Staff can be supported by the provider through performance management and staff supervision. It was indicated to inspectors by the provider that formal staff supervisions were to be done every six to eight weeks and that the new person in charge was to commence supervisions for staff working in the centre with a schedule in place. However, some staff spoken with indicated that they had not receive any formal supervision in some time with one staff stating that they had requested supervision but not received it. On the second day of inspection, supervision records were requested which were subsequently provided. An inspector reviewed the supervision records for five staff members. None of these staff members had records of any formal supervision conducted in 2024. In the provider's PAR response submitted by the provider shortly before the current inspection, it was indicated that supervisions were one of the provider's internal processes in place to enable staff to raise concerns.

Such processes also included a complaints process, access to a designated officer and staff team meetings. The visitors' log indicated that the designated officer and complaints officer had visited the centre in recent times while information about both was on display in the centre. A folder with notes of staff meetings in the centre was reviewed during this inspection. This most recent notes of staff meetings in this folder were from March 2024 and August 2024. The notes of the latter indicated that relevant matters were discussed including safeguarding, medicine errors and residents goals. When queried if there had been more recent meetings beside these two, it was indicated that one had been done shortly before the inspection and that one had taken place in July 2024 also but that the notes of these had not been completed.

In the recent PAR response, it was also indicated by the provider that they had action trackers in place to monitor the status of actions identified in internal and external inspections. An inspector requested to view such trackers and was provided with a tracker for actions from previous inspections by the Chief Inspector. The inspector was informed that the provider was trialling such trackers. A report of a May 2024 internal provider unannounced visit to the centre was also reviewed by

the same inspector. This report did consider relevant matters related to the quality and safety of care and support provided in the centre and included an action plan for any issues identified which assigned time frames and responsibilities for completing actions. This action plan had not been updated to reflect progress with these actions while it was evident that some actions had not been completed. For example, residents' meetings were not taking place consistently despite this being raised in the May 2024 provider unannounced visit. An action plan was in place for the centre's most recent annual review which had been updated to reflect progress.

Aside from provider unannounced visits and annual review, an audit schedule was in place for the centre. This set out a frequency for when audits were to be done although it did not indicate what months these audits were to take place. Records reviewed did indicate that audits were being conducted in various areas such as medicines, safeguarding and finances. Despite this, while the current inspection had a particular focus given the recent information of concern received, regulatory actions were found in all regulations reviewed during this inspection. This included regulations where regulatory breaches had been identified during earlier inspections in 2024 such as Regulation 8 Protection and Regulation 29 Medicines and pharmaceutical services. While there had been some improvement, particularly from the January 2024 inspection, the findings of the current inspection indicated that the management systems in operation continued to need improvement to ensure that the services provided in the centre were safe, appropriate to residents' needs, consistent and effectively monitored.

Judgment: Not compliant

Regulation 31: Notification of incidents

Under this regulation, injuries sustained by residents, which are not serious injuries, must be notified to the Chief Inspector on a quarterly basis. While notifications of such minor injuries had been submitted for the second quarter of 2024, 21 minor injuries had been notified a day late. This regulation also requires the Chief Inspector to be notified of allegations or incidents of a safeguarding nature within three working days. This requirement had not been complied with during either of the earlier inspections in 2024. Since the April 2024 inspection number of these notifications have submitted and most were submitted in a timely manner. However, a recent safeguarding notification was only notified 10 working days after a relevant incident had occurred and been reported. The late notification of this matter had been acknowledged as an error in advance of this inspection.

During the current inspection, when reading a recent incident report an inspector noted reference which appeared to suggest that a safeguarding allegation had been made and was managed as a safeguarding concern with follow up on the matter documented. This had not been notified to the Chief Inspector at the time of this inspection. During the feedback meeting for the inspection, confirmation was sought as to whether this had been reported as a safeguarding concern to the Health

Service Executive (HSE) Safeguarding and Protection Team. In the days following this request, this matter was notified retrospectively to the Chief Inspector with the notification form indicting that it had been reported to the HSE Safeguarding and Protection Team. While it was noted that there had been no grounds for concern found in this matter, the retrospective notification submitted following this inspection along with other matters highlighted under this regulation, confirmed that not all required matters had been notified in a timely manner in recent months.

Judgment: Not compliant

Quality and safety

Improvement was found to be required in areas which impacted the quality and safety of care and support received by residents. This included aspects of medicines management while gaps were identified in some healthcare records.

As highlighted earlier in this report, in the recent PAR response, the provider had indicated that quality improvement was needed regarding medicines management. This was reviewed during this inspection and, while there some improvement in this area from the January 2024 inspection, there continued to be a high volume of medicines errors reported. It was indicated though that there had been follow-up in response to such errors. Medicines management plays a role regarding the provision of healthcare for residents also. This inspection found that residents did have access various health and social care professionals and had support plans in place related to their health needs. However, some gaps were identified regarding relevant records related to residents' health. This included gaps in one resident's fluid balance records which was important given the assessed needs of the resident in this area.

Although, support plans were in place related to residents' health, some improvement was identified in some of the guidance available for staff when supporting residents. Notably, one resident could tear their bed linen but from reviewing the resident's personal plan and various support plans, there was no guidance in this area. Having such guidance in place is important as it promotes a consistent approach in supporting the relevant resident in this area. Where necessary residents did have positive behaviour support plans in place which did provide recently reviewed guidance in other relevant areas. Some of the residents living in this centre could display certain behaviours which contributed to some of the safeguarding notifications that had been received from the centre. The overall volume of such notifications was high since the April 2024 inspection which raised concerns around resident compatibility.

Regulation 12: Personal possessions

During this inspection, improvement was identified under this regulation in the following areas:

- Two different logs of possessions owned by a resident were kept but neither were being updated to reflect clothes that had been torn by the resident while it was indicated that recent clothes purchased for the resident had not been added to either log. As such it was unclear if all clothes listed in this log were still in the possession of the resident or not.
- Documentation relating to the same resident, including a document reviewed the day before this inspection commenced, indicated that they had an electronic razor. However, no such razor was listed on either of the resident's personal possessions logs. This electric razor could not be located on the first day of inspection and on the second day of inspection it confirmed that the resident did not have such a razor.
- Each resident had their own designated space and basket for storing their personal care items in the centre's utility room. When viewing these on the first day of inspection it was seen that personal care items for some residents were stored in the baskets of other residents. After this was highlighted, the storage of such items was found to have been improved on the second day of inspection.
- Signage on display indicated that a colour coded system was to be used for residents' towels and linen. When viewing the centre's hot press where such items were stored, it was noted that designated shelving areas were marked for five of the six residents living in the centre. However, it was apparent that the colours of some towels and linen in these areas did not correspond with the colour coded system signage. An inspector was informed that this was due to family members buying residents linen or towels of a different colour. As for the resident who did not have a shelving area marked in this hot press, it was indicated that the resident should have had an area for this in the hot press but did have linen stored in their bedroom while their towels were being laundered.
- Five residents living in this centre were supported with their finances by the provider. It was noted though that the process for these residents to gain access to money in their own bank accounts could take time and would involve multiple different personnel within the provider. The nature of this process could limit residents' control over and access to their own finances. It was acknowledged though that the provider had recognised such arrangements as being a restriction on the residents.
- Two of the residents in this centre did not drink water. A previous concerns had been raised when one of these residents had a receipt for a soft drink that was purchased when they had a meal out. This concern was queried with the provider and an explanation was put forward for this. Following this a review of other transactions for 2024 identified seven other instances where named soft drinks had been purchased for these two residents according to receipts. Inspectors were informed that these transactions had not been specifically queried with staff involved but that they had been raised in a general sense at a recent staff meeting.

Judgment: Not compliant

Regulation 13: General welfare and development

The provision of activities away from the centre had improved overall since the January 2024 inspection where such matters had been highlighted an area in need of improvement. Examples of activities residents did included completing a personal development course, going swimming and horse riding. Some areas for improvement though were noted during this inspection. These included;

- Some gaps in activity record were noted for one resident. These included some days when the resident was not recorded as having done any internal or external activities.
- The centre did not have access to two vehicles at all times. It was highlighted that this posed challenges in getting all residents out as not all residents could travel together on the centre's one dedicated vehicle.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Records of food purchased for residents in the centre was available and during the inspection it was seen that various food items were stored within hygienic conditions in the centre. It was highlighted though that due to the needs of one resident, other residents could not have certain food within the centre. Meals were observed to be prepared in the centre on both days of the inspection. Records of food provided to residents were kept in the centre but these lacked detail (this is addressed under Regulation 21 Records). It was highlighted that one resident could refuse food. Despite this, relevant support plans for the resident in this area made no reference to this. Staff spoken with about this matter gave different responses as to how they would encourage the resident with their food while a general supportive measure outlined in the resident's support plans was not mentioned by such staff.

Judgment: Substantially compliant

Regulation 27: Protection against infection

This regulation was not reviewed in full but during this inspection it was observed that one resident was sleeping on a mattress that was visibly unclean. This posed a risk from an infection prevention and control perspective. Different information was provided as to how this mattress was being cleaned and inspectors were informed

that there was no protocol or risk assessment in place related to this. On the first day of inspection, it was indicated that the provider was seeking to get a new mattress for the resident. During the inspection's feedback meeting it was indicated that a new mattress had been obtained and would be brought out to the centre in the followings days. While this was noted, varied information was provided as to how long the resident had been sleeping on this unclean mattress with a member of management indicating that it had been first identified two weeks before this inspection, a staff member indicating that they had raised concerns about the mattress a month prior and another staff member indicting that the mattress had been unclean for a number of months.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Significant concerns were raised around medicine management practices in this centre during the January 2024 inspection particularly related to PRN medicines (medicines only taken as the need arises) and controlled medicines. Controlled medicines, given their nature, require stricter checks, record keeping and additional storage measures compared to other medicines. Some improvement was noted regarding medicine management generally during this inspection. For example, appropriate storage facilities were provided while daily checks for controlled medicines had improved. Despite this, there continued to be areas in need of improvement. These included;

- It was identified that a number of PRN medicines prescribed for residents did not have protocols in place to guide staff about their use. For example, one resident had a PRN medicine prescribed related to their nutritional needs but further information was needed for this to provide guidance for staff as to when it was to be administered.
- Guidance in place in relation to PRN medicines did set out a maximum daily dose for each medicine but did not specify the minimum duration between administrations of such medicines. Also, it was not clearly set out in the documentation in place how often a resident should receive specific medicines prior to review, and the prescription records did not contain this information. This was not consistent with the provider's policy and procedures in this area.
- It was not indicated on some medicines, such as creams and eye drops, when they had been first opened or used.
- In recent months there had been a high number of medicine errors occurring in the centre. These included documentation errors and occasions where medicines had not been administered as prescribed. It was indicated though that such instances had not adversely impacted residents and there was evidence of follow up after these errors were identified.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

All residents had personal plans in place and some were in the process of being updated but during this inspection improvement was required in the following;

- A resident who could tear bed linen had no guidance in their personal plan around how to support the resident in this area.
- Some assessments of needs for one resident had not been reviewed since February 2023.
- A person-centred planning meeting for one resident to identify goals for them was overdue with their previous one last taking place in January 2023.
- Some goals identified for other residents through person-centred planning lacked documented evidence to confirm if or how these had been progressed. For example, one resident had a goal to complete an event and while this was marked as being completed, it was unclear what this event was.

Judgment: Substantially compliant

Regulation 6: Health care

Residents did have support plans around their assessed health needs and there was evidence that residents availed of health and social care professionals such as general practitioners, occupational therapists and chiropodists. Documentation reviewed also indicated that residents were supported to avail of vaccines. However, when reviewing records during this inspection some gaps were observed relating to some residents' health needs. For example, there were gaps in one resident's fluid balance records while another resident had gaps in their daily dental tracker records.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Where required residents had recently reviewed positive behaviour support plans in place to provide guidance for staff in encouraging residents to engage in positive behaviour. Staff spoken with during this inspection demonstrated a good knowledge of these and there was reference in notes of an August 2024 staff team meeting that these were discussed. However, it was noted for four positive behaviour support plans that they had between 10 and 12 staff signatures on these each of these plans to confirm that such staff had read them. As highlighted under

Regulation 15 Staffing, a greater number of staff had worked in the centre in recent months.

The provider had processes in operation to review restrictive practices. As mentioned under Regulation 21 Records, there was an approved restrictive practice in use in the centre that the door to the staff office would be locked when unsupervised or during particular meetings. An inspector noted reference in a recent complaint record which indicated that the staff office door had been locked at a time other than it was approved for. When queried with management of the centre as to whether the staff office had been locked on more occasions than it was approved for, it was indicated that they were not aware of any other such occasion. A staff member spoken with indicated that the office door was locked when medicines were being prepared but this was not in keeping with restrictive practices documents reviewed.

Judgment: Substantially compliant

Regulation 8: Protection

As was found during the April 2024 inspection, there was a high level of safeguarding incidents occurring in the centre involving residents. While such matters were being appropriately reported with safeguarding plans put in place, the continued high level of such incidents raised concerns around the compatibility of the current resident mix to live together within the existing environment of the centre. During the April 2024 inspection, it was indicated that consideration was being given by the provider to conducting works in an external garage at the rear of the centre in response to such matters. Such works were intended to give more space for residents given that between residents and staff, there could be up to 12 people present in the centre at certain times. When queried on the current inspection it was indicated that the potential of conducting works to the external garage had not progressed so the space available for residents remained the same

In the month leading up to the current inspection, there had been a noticeable increase in the amount of safeguarding incidents. Some of these were linked to the presentation of one resident who it was acknowledged was going through a difficult period related to their mental health. Aside from the incidents involving this resident that were managed through safeguarding processes, incident records reviewed during this inspection referenced other instances where the resident was described as shouting, roaring, throwing items and/or banging furniture. In some of these incidents reports it was indicated that other residents were not impacted. However, staff spoken with during this inspection suggested that other residents could be impacted. For example, one staff member highlighted that when the resident was shouting or roaring, the other residents did not get a break. In addition, during the inspection, when the resident was seen to be heightened, two residents were redirected out of a communal area in response.

Aside from the safeguarding incidents which involved residents impacting on one another, the Chief Inspector had also been recently notified of an alleged safeguarding incident from the centre. This allegation was in the process of being investigated and it was noted that there was no safeguarding risk to residents at the time of the inspection related to this matter. However, the nature of the allegation, given previous allegations made, caused concern. In addition, while information provided indicated that the allegation had been reported promptly, other information provided indicated that appropriate and immediate safeguarding measures had not been taken in a timely manner once reported.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents were generally treated respectfully by staff across both days of inspection but the following was noted during the inspection:

- At one point during the second day of inspection, a resident requested for a particular music artist to be put on. A staff member subsequently turned on some music but it was not from the artist requested. It was acknowledged though that other requests in this area during the inspection were adhered to.
- A provider unannounced visit report from May 2024 indicated that resident meetings were to be done weekly. Such meetings can used to discuss various matters with residents and to give them information. However, despite the findings of the May 2024 provider unannounced visit, records reviewed during this inspection indicated that since then only five resident meetings had taken place, most recently during July 2024.
- Records reviewed did not indicate if residents were offered choice in their meals with one staff member indicating that food was bought for residents based on their likes. However, there was no evidence that residents were consulted with about menu planning in the centre.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Blossomville OSV-0001822

Inspection ID: MON-0043819

Date of inspection: 04/10/2024

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Registered Provider will ensure implementation of active recruitment measures for permanent staff positions to fill vacant lines. In an effort to explore employment further, there are planned recruitment days in December 2024 and January 2025 in both the Limerick and Cork areas. This action aims to build staff within the service and reduce reliance on agency staffing arrangements. The Provider is currently looking at the possibility of international recruitment for various staff roles, however this is currently at infancy stage. The Person in Charge will ensure the centre roster is reviewed and maintained daily to identify and address gaps in staff coverage as required. The Registered Provider will ensure implementation of an approved agency staff system. A list of compliant agency staff will be maintained by the Registered Provider's HR department. To monitor the compliance with Schedule 2 requirement, the Person in Charge will conduct a regular staff file audits with the support of the HR. department. To improve communication within the centre there is a supernumery Person in Charge on site on a full-time basis supporting staff communication on both shift patterns and bridging any gaps identified. In addition to enhance communication, the Person in Charge will ensure that staff supervision will be occur every 6-8 weeks in a planned schedule.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Following the inspection on October 3rd 2024, the Person in Charge can confirm the implementation of enhanced food record monitoring charts are in situ and which indicate and record that residents have received appropriate nutrition daily. Currently there is one resident who requires a fluid chart to be completed daily. This is to be completed by staff, with oversight from SCW/ Nurse on duty. The Person in Charge will monitor same through weekly reviews.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

The Registered Provider wishes to assure and confirm to the Chief Inspector that a regular management structure has been in place in the Designated Centre since the January 2024 inspection. Given the ongoing issues and to effectively monitor the centre the Registered Provider can confirm that it has reviewed the management structure of the centre and will put in situ a new PPIM/Area Manager to support the centre and provide stronger governance and oversight.

The Registered Provider would like to confirm that while gaps were identified in some supervision records, supervision was completed for a number of staff. To address the identified gaps, the Person in Charge will conduct supervision every 6-8 weeks as stated in Regulation 15 of this response. The Person in Charge will ensure implementation of a structured staff supervision system. The Person in Charge will conduct direct supervision of all grades of the staff within the designated centre prior to delegating supervision responsibilities to Social Care Workers and Nurses for Healthcare Assistants.
In addition to staff supervision the following supports are in place to assist staff to make report of any concerns:
• Reporting on the Registered Providers internal incident management system (XYEA)
• Staff have access to various managers/members of the senior management team including; PIC, Area Manager, Head of Client Services, Principal Social Worker, Designated Officer, Quality & Risk Manager, CEO and a 24 hour on call support .
• Externally staff can raise concerns to the HSE Safeguarding team, HIQA, Tusla and the Confidential Recipient.

To enhance the protection of resident's, the Registered Provider has assigned its Designated Officer to solely focus on the following.
•Safeguarding Audits.
•Reviews of Safeguarding plans.
• Attending designated centre team meetings.
• Delivering Safeguarding Vulnerable Adult Training
• Conducting unannounced visits to residential centres.
The Principal Social Worker also supports the designated officer with the above.
The Person in Charge would like to confirm that minutes from the team meeting of July 2024 are now typed and available in the designated centre's team meeting folder.
The Registered Provider confirms that it uses action trackers to monitor the progress and status of identified actions arising from both internal and external inspections. The Registered Provider acknowledges the shortcomings identified regarding some open actions and to improve monitoring of same, the Registered Provider will implement a Person in Charge feedback report which will incorporate a number of key process indicators (KPI) such as medication incidents, safeguarding incidents and status on action items arsing from 6 monthly, annual reviews and HIQA inspections. This report will be presented to members of the senior management team which in turn will enhance the Registered Provider oversight of the service.
The Registered Provider has engaged the services of an external consultancy with

expertise in the areas of regulation and compliance to review staff roles and responsibilities and staff rostering in all its designated centres including Blossomville.
The Registered Provider can confirm to the Chief Inspector that it has also engaged this company to review this centre in its totality through a number of unannounced visits and audits over the forthcoming 12 month period with a commitment to implement any recommendations and to support the Person in Charge to regain compliance and provide a safe service to the six residents of the centre.
To educate and support Persons in Charge, nurses and social care workers in the areas of compliance and regulation the Registered Provider continues to provide a 3 day training programme re Regulations in Context. The Registered Provider is committed to provide this training to all staff grades.

The Registered Provider will ensure that a standardised audit schedule is implemented throughout all designated centres.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

With reference to the safeguarding allegation on the 16/09/2024, this was not reported as it was deemed to be a duplicate incident which has been previously notified to the Chief Inspector on the 9th of June 2024.

To ensure compliance with the regulatory reporting timeframe, a team meeting was held 30th of September 2024 with staff to reiterated the importance of adhering to the reporting timeframes. In addition a flow chart highlighting required timeframes is now displayed in the centres office to guide and support staff.
As outlined under Regulation 23, the Person in Charge feedback KPI report will include the status of all notifications.
The Person in Charge will ensure enhanced incident oversight through twice weekly reviews of the incidence management system, with immediate review of any serious incidents. A comprehensive notification checklist has been implemented within the Safeguarding folder, detailing incident classifications and severity assessment guidelines.
The Registered Provider will ensure timely incident reporting through the presence of the on-site Person in Charge, facilitating prompt review and appropriate escalation of incidents.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:

To come into compliance with Regulation 12, the Person in Charge will ensure that all personal property logs will be reviewed and updated.
Going forward these documents will be live and staff will receive instruction from Person in Charge to support on how to implement and maintain these property logs.
Regarding a reference in a support plan to a resident's electric razor, the Person in Charge can confirm that the entry of (electric razor) was incorrect and the resident uses

a manual razor, which was available in the resident's toilet bag. This support plan was corrected post inspection by the Person in Charge.
The Person in Charge can confirm that the storage of resident's personal care items continues to be maintained as acknowledged on the second day of inspection.
In relation to resident's personal linen, one resident chooses to have their linen stored in their bedroom wardrobe. Staff maintain the color coded system for the residents but families are not obliged to maintain same if purchasing linen as a gift to residents. In the event of such gifts being received by residents they will be recorded (including color) in the resident's property logs.

The Registered Provider does acknowledge that the current arrangements re. resident's finances is restrictive as evidenced by the restrictive practice process. However, the Registered Provider continues to liaise with banks and private companies to address this complicated issue to ensure the resident's access to finance is flexible and safe.
The Person in Charge wishes to clarify that two of the residents choose to drink water. While 7 receipts relating to these residents were noted to have soft drinks identified rather than water, the Person in Charge is satisfied that no financial irregularities occurred. To enhance oversight of same, the Person in Charge will audit all resident's receipts monthly and where any discrepancy is found i.e. soft drink rather than water, this will be queried with the identified staff member who supported the resident with these transactions.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:

The Person in Charge has implemented a weekly comprehensive activity planning system through the creation of detailed activity calendars that account for service resources, including vehicle availability. While a second bus may not always be available to the residents, when one is available it will be utilised to the maximum to facilitate additional outings for residents if they wish to avail of same. All residents are afforded the opportunity to avail of trips on the centres existing bus.
The Person in Charge will ensure the recording of all activities, including those offered and completed or refused, any cancellations and reasons for same. Indoor activities will be planned to ensure continuous engagement opportunities.
The Person in Charge will ensure the monitoring of resident's engagement in activities through weekly reviews of activity preferences and this will inform future planning.
Weekly activities are an agenda item at the residents meeting.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:

As outlined under Regulation 21 of this response the Person in Charge can confirm the implementation of enhanced food record monitoring charts that indicate and record that residents have received appropriate nutrition needs daily.

Regarding the resident who may choose to refuse food, they have had their support plan reviewed and updated to reflect this possibility and how to address same. The Person in Charge has updated the team in relation to this updated document
To support and facilitate education to the staff the Registered Provider will provide training in relation to Dining with Dignity.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:

The Registered Provider can confirm a new waterproof mattress has been supplied for the identified resident since 14th October 2024. The maintenance/cleaning of this resident's mattress is included in the daily cleaning schedule, checked by the senior staff on duty (nurse/social care) and monitored by the Person in Charge.
Due the resident's sensory needs they may refuse to use bed linen, not withstanding this the Person in Charge will ensure that they are offered fresh bed linen daily. Acceptance /refusals of same will be documented with the Person in Charge reviewing these records on a fortnightly basis.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

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

The Registered Provider will ensure comprehensive review and implementation of PRN medication protocols within the service. New protocols have been created for all prescribed PRN medications in the designated centre, with quarterly reviews scheduled and immediate protocol creation for any newly prescribed PRN medications.
The Person in Charge will ensure that identified medications eg. topical medications will be labelled to reflect opening dates. This will be recorded in the monthly medication audits.
The Person in Charge wishes to confirm to the Chief Inspector that medication education will be an agenda item for all team meetings. The Person in Charge will monitor and track all medication errors and address same through this education in the aim to reduce errors. Where repeated errors are noted identified staff will be directed and facilitated to retrain and will be supervised during drug administration following retraining to ensure competency.

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:

The Registered Provider can confirm that the personal plan of the resident who may refuse/tear bed linen has been reviewed and updated to include staff guidance to

address these issues.

The assessment of needs for all residents has been reviewed in particular the resident as referenced in this report.

In relation to the PCP meeting for one resident which was outstanding the Registered Provider can confirm that several attempts had been made to set dates for same with the resident's mother however she was unable to attend due to personal issues. The Person in Charge continues to engage with the resident's mother to secure a date. Goals have been identified and are in place in consultation with the resident.

The Person in Charge will ensure that all goals being progressed or which have been attained will be evidenced by written/photographic evidence. Oversight of this will be provided by the Person in Charge on a quarterly basis during the PCP reviews.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

The Person in Charge can confirm that they have reviewed the documentation and recording of the use of a residents prescribed toothpaste. The administration of this prescribed toothpaste will now be captured on the medication record in line with all prescribed medications. The Person in Charge will monitor these records on a monthly basis as part of the medication audit.

In relation to a resident's fluid chart which requires daily monitoring, this will be completed by staff with daily oversight from SCW/ Nurse. The Person in Charge will provide monitoring of same.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

The Registered Provider will ensure that the restrictive practice relating to the office door in the registered centre will be reviewed at the next restrictive review on December 6th.2024. The Person in Charge is currently recording data re the locking of the door which will be presented to the MDT at the review meeting to detail it usage.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

The Registered Provider can confirm that a compatibility assessment has been conducted by the MDT to determine the compatibility of all residents who live in the designated centre. The full recommendations of this assessment will be shared with the lead inspector. Some of the recommendations include:
• Given the complex profile of service users in Blossomville, ongoing training regarding

the complex interplay between intellectual disability, behavioural profile & mental health needs would be beneficial for frontline staff.
• Residents would benefit from a separate vehicle, with unrestricted access. Currently Blossomville has access to one bus 24/7 and second is available only between 4pm-9am Monday to Friday and 24 hours at the weekend. The second vehicle should also be available 24/7 to facilitate social outings, medical appointments, home visits. Currently there are scheduling conflicts with six vehicle users 9am to 4pm Monday to Friday. The Registered Provider wishes to confirm that they will submit a business case for the purchase of an additional bus.
• All residents of Blossomville would benefit from an additional multipurpose space separate to their home to allow them space to regulate when a peer is in periods of high elation or as an alternative to offer this resident an individualised space on site with staff. The garage has been identified space to facilitate this but requires some renovations and the costs for same have been requested to an external funder. The Registered Provider has committed to fund these renovations in the absence of receipt of external funding.
In relation to the safeguarding concern involving a staff member, the Registered Provider does acknowledge that there was a delay of approx. 60 minutes in the actions taken following an incident. The staff member was under supervision for 40mins of this time and in the presence of other staff. However, once the Person in Charge was made aware he implemented immediate action and the staff member was relieved of their duty. A Trust in Care investigation is now complete and a final report issued. The disciplinary process will now be evoked and the Chief Inspector will be informed at its conclusion.
Safeguarding is an agenda item at staff supervisions and team meetings. The Designated Officer conducts unannounced safeguarding audits which involve discussions with staff re their knowledge of and any concerns re safeguarding. The Designated Officer also conducts safeguarding PSF1 audits with the Person in Charge. The Registered Provider has also ensured that Safeguarding Vulnerable Adults Training is provided to all staff. All staff in the designated centre have up to date training in this area. The Registered Provider's Safeguarding Committee provides oversight on all safeguarding incidents. Also as per Regulation 23 of this compliance plan to enhance the protection of resident's, the Registered Provider has assigned its Designated Officer to solely focus on the following.
•Safeguarding Audits.
•Reviews of Safeguarding plans.
• Attending designated centre team meetings.
• Delivering Safeguarding Vulnerable Adult Training.
• Conducting unannounced visits to residential centres.
The Principal Social Worker also supports the designated officer with the above.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

The Person in Charge acknowledges that the request by a resident regarding a specific music artist was not facilitated however this was a deceased Irish artist who was unknown to the identified staff member who was not of Irish origin. The staff member did facilitate the resident with alternative music.
The Person in Charge will ensure continuation of weekly resident's meetings, with formal minutes recorded by the Person in Charge or Social Care Worker on duty. The Person in Charge wishes to assure the Chief Inspector that these meetings have been held

consistently each week following this recent inspection.
The Registered Provider will ensure enhancement of resident's choice in meal planning through dedicated discussion with the residents and the Person in Charge uses picture prompts during weekly meetings, enabling residents to express preferences and consent to meal choices for the upcoming week. Staff will accommodate these choices accordingly.

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	31/03/2025
Regulation 12(3)(a)	The person in charge shall ensure that each resident uses and retains control over his or her clothes.	Substantially Compliant	Yellow	30/11/2024
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests,	Substantially Compliant	Yellow	30/10/2024

	capacities and developmental needs.			
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Substantially Compliant	Yellow	30/10/2024
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.	Not Compliant	Orange	31/01/2025
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	31/01/2025
Regulation 18(3)	The person in charge shall ensure that where residents require assistance with eating or drinking, that there is a	Substantially Compliant	Yellow	31/01/2025

	sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.			
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	10/10/2024
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	10/10/2024
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.	Not Compliant	Orange	31/12/2025
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall	Substantially Compliant	Yellow	31/12/2025

	carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 23(3)(a)	The registered provider shall ensure that 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.	Not Compliant	Orange	31/03/2025
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the	Substantially Compliant	Yellow	31/01/2025

	care and support provided to residents.			
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	14/10/2024
Regulation 29(4)(b)	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 medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	25/10/2024
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing	Not Compliant	Orange	10/10/2024

	within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.			
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Orange	31/12/2024
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	15/11/2024
Regulation	The person in	Substantially	Yellow	15/11/2024

05(6)(b)	charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Compliant		
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	15/11/2024
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that	Substantially Compliant	Yellow	10/10/2024

	resident's personal plan.			
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.	Substantially Compliant	Yellow	06/12/2024
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	14/03/2025
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.	Substantially Compliant	Yellow	15/10/2024
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Substantially Compliant	Yellow	15/10/2024