Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Centre 4 Cheeverstown House Residential Services
Name of provider:	Cheeverstown House CLG
Address of centre:	Dublin 6w
Type of inspection:	Unannounced
Date of inspection:	12 December 2024
Centre ID:	OSV-0004927
Fieldwork ID:	MON-0045583

About the designated centre

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

This designated centre provides 24-hour care, seven days per week for male and female adults. The centre is located on a campus residential service in the area of South Dublin. The centre comprises of three residential houses and can support 15 residents most of whom have mobility issues, and require support with their emotional and healthcare needs. There is a full-time person in charge and the front-line staff are primarily made up of clinical nurse managers, staff nurses, care assistants and some social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

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 12 December 2024	20:50hrs to 22:55hrs	Karen Leen	Lead
Friday 13 December 2024	10:30hrs to 16:30hrs	Karen Leen	Lead
Thursday 12 December 2024	20:50hrs to 22:55hrs	Erin Clarke	Support
Friday 13 December 2024	10:30hrs to 16:30hrs	Erin Clarke	Support

What residents told us and what inspectors observed

This unannounced safeguarding thematic inspection was carried out to assess the provider's regulatory compliance with the relevant safeguarding regulations and adherence to the National Standards for Adult Safeguarding. The inspection was carried out by two inspectors, commencing at night-time on the first day of the inspection and concluding on the following day. This approach allowed inspectors to observe the centre's operations during both night-time and daytime hours.

The designated centre is located on a congregated mixed-use campus setting with three other designated centres with an overall capacity of 54 residents. The centre comprises three separate bungalow-style houses located near each other. In addition to the residential service, the campus also contained a school, a restaurant, and several administration offices. The campus was in the process of decongregation, with a number of residents already having transitioned to community-based houses. At the time of the inspection, two residents were awaiting transfer to their new homes from the designated centre.

The centre was registered to accommodate 13 adult residents, and there were two vacancies at the time of this inspection. Two bungalows accommodated five residents, and the other bungalow accommodated three residents. The inspectors had the opportunity to meet and spend time with all of the residents who lived in the designated centre and to visit all three bungalows over the course of two days.

On arrival at one house at 9pm, the inspector was greeted by a healthcare assistant who provided a thorough overview of the centre and the needs of the residents living there. One resident was asleep in bed, a second resident was in bed watching television in their room, and a third resident was spending time in their bedroom before retiring for the night. The inspector spoke with the resident watching television, who shared that they were enjoying a dog show, one of their favourite programs.

The inspector also met with the night manager and the night 'float' staff nurse, who introduced themselves and were available later in the evening during medication administration. All interactions with residents were pleasant and respectful. For example, residents were offered a cup of tea while in bed after receiving their night-time medicine. Inspectors spoke with the night manager who gave the inspectors an overview of the supports in place for residents in the designated centre. This discussion focused mainly on plans in place for residents in the event of an emergency for example if a resident was to present unwell or in the case of a fire. Inspectors found that the night manager had a strong understanding of residents support needs and was providing staff with appropriate supervision and support.

The inspectors met with one resident on the first evening of the inspection. The resident expressed that they do not like living in the house and do not get along with another peer who also resides there. The resident shared that the staff are

"really lovely" and do their best to support them, but they remain very unhappy with their current living arrangements. The resident explained that when conflicts arise with their peer, they typically retreat to their room. They noted that they spend a significant amount of time in their room or seeking activities to keep themselves occupied. The resident also mentioned that they would be moving to a new house soon but felt the process had been very lengthy and seemed to have slowed down.

On the second day of the inspection inspectors spoke to one resident who was getting ready to attend a carol service. The resident told the inspectors that they liked living in their home. The resident spoke to inspectors with a staff member supporting the resident. The staff informed the inspector that the resident really enjoyed music and that they had access to a musical keyboard and radios were in place throughout the house. The resident spoke to the inspectors about staff that used to work in the centre and things that they liked to do including going to the carol service with staff later in the morning. The resident told the inspectors that they liked to go out for walks in the local area followed by lunch or dinner in a restaurant within the community.

Over the course of the inspection, the inspectors observed that there was a warm, friendly and welcoming atmosphere in each of the areas visited. Each of the premises were found to be homely and comfortable. However, inspectors found that the centre was limited in communal spaces in two of the houses. On review of the statement of purpose for the designated centre two houses had identified relaxation rooms for residents to avail of. However, inspectors found no such evidence of an alternative relaxation room for residents. One relaxation room was to be located to one house in the centre where peer-to-peer compatibility issues had been highlighted. Furthermore, during a walk through of the designated centre inspectors found that the room identified as a relaxation room was not fit for purpose and did not offer any items or equipment which would deem the room functional or inviting for residents to use.

Inspectors observed support staff to be very familiar with residents communications preferences. Support staff assisted residents at times throughout the inspection to communicate fully with the inspectors about their home and activities that they like to participate in. Support staff spoken to discussed residents individual needs. The centre had suffered a recent bereavement and support staff were helping residents to navigate through their grief. Support staff discussed how the resident was supported to receive palliative care in their home with the support of the hospice. Staff spoken to discussed the importance for both the resident and peers in the house that this service was supported by the provider. Staff discussed relevant training they had completed to ensure safe care while supporting a resident through end of life care.

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

This unannounced safeguarding thematic inspection was conducted to assess the provider's compliance with relevant safeguarding regulations and adherence to the National Standards for Adult Safeguarding. The inspection focused on the systems and practices in place to protect residents from abuse and promote their safety and well-being.

Inspectors found that the provider had ensured the centre was well-resourced, with appropriate staff levels and facilities. However, significant improvements were required in the documentation, review systems, and escalation processes to ensure that all residents were effectively protected from abuse and that safeguarding measures were robust.

While the provider was aware of compatibility issues between some residents, inspectors identified deficiencies in the review systems. Specifically, the impact of negative behaviours on individual residents in one house within the designated centre was not adequately captured. Incidents were recorded using behavioural support charts, reviewed only at a local level, and often deemed unnecessary for further review by the provider's safeguarding team. This limited oversight resulted in missed opportunities to escalate safeguarding concerns appropriately.

Inspectors acknowledged the provider's efforts to address compatibility issues by identifying a new home for one resident and developing a transition plan. However, due to insufficient review processes, incidents involving residents were not escalated through the correct pathways. Consequently, safeguarding plans failed to reflect the potential impact of these incidents on residents, undermining their effectiveness.

The centre had a clearly defined management structure, with roles and lines of authority explicitly outlined. The person in charge was employed full-time and supported by two clinical nurse managers. They reported to an area manager, the head of supported living, and ultimately, the Director. While the management structure was well-established, inspectors found that systems for safeguarding residents from abuse required further review to improve communication and ensure the timely escalation of potential safeguarding concerns.

The centre's staffing included a mix of nurses and care assistants. The skill mix and staff complement were appropriate to meet the needs of residents. To maintain continuity of care, staff leave was covered by regular relief and agency staff. The person in charge maintained up-to-date planned and actual staff rotas to ensure transparency and consistency in staffing.

Regulation 15: Staffing

The inspectors reviewed the centres actual and planned rosters from August, September, October and November 2024 and found that the registered provider had ensured the skill-mix and staffing levels allocated to the centre were in accordance with the residents' current assessed needs. Staffing levels were in line with the centre's statement of purpose and the needs of its residents. The provider ensured that were agency staffing was required in the designated centre that they were supported on shift with regular staff and that the agency number did not exceed two in any day reviewed by the inspectors.

Inspectors spoke to ten staff during the course of the two day inspection, staff spoken with demonstrated good understanding of the residents' needs and goals. Inspectors found that staff had a good knowledge of how to respond to residents needs should an issue or concern arise in the designated centre. Staff spoken to could give a wide range of information on each residents likes, dislikes and what each resident would like to see happen in their future.

Inspectors found that staff spoken with had a good understanding of residents' individual personalities and needs, and supported them in a kind and respectful manner.

Judgment: Compliant

Regulation 23: Governance and management

Inspectors found that while there were clear lines of authority and accountability within the designated centre, the inspection identified significant areas requiring improvement in the oversight and local governance systems. Specifically, enhancements were needed in the documentation and reporting of incidents to effectively address risks related to safeguarding and the protection of residents. Enhanced communication and oversight within the governance structure is essential to achieving these improvements.

A number of peer-to-peer incidents had not been reviewed by appropriately qualified personnel, either within the provider's governance structures or by external stakeholders. This lack of review underscored the need for strengthened governance measures to reduce the risk of harm and to promote residents' safety and well-being.

Staff interviewed during the inspection highlighted ongoing compatibility and safeguarding risks, particularly in one house within the centre. Although safeguarding plans were in place for residents, the failure to report and escalate all relevant incidents resulted in critical information being excluded from these plans. This gap in safeguarding oversight compromised the effectiveness of measures aimed at addressing and mitigating risks Further findings on safeguarding and protection will be discussed in detail under Regulation 8: Protection.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

While the statement of purpose contained the information required by Schedule 1 of the regulations, some of this information was found to be inaccurate. For example, the inspectors found that the statement of purpose did not accurately reflect two of the houses within the designated centre. Inspectors found that both the statement of purpose reviewed on the day of the inspection and previously submitted to the office of the Chief Inspector of Social Services by the provider, stated residents living in two houses in the designated centre had access to a relaxation room. The statement of purpose states that "the Relaxation room, which serves as a place for individuals to relax in a comfortable environment". As discussed within the findings of this report, inspectors observed no such area for residents to avail of in their home.

Judgment: Not compliant

Regulation 31: Notification of incidents

Through a review of documentation inspectors found nine separate incidents that occurred in the centre between September 2024 and November 2024. These incidents had not been reviewed appropriately and therefore had not been submitted to the office of the Chief Inspector in line with the regulation.

Judgment: Not compliant

Quality and safety

Although the provider demonstrated commitment to safeguarding through a review of placements and transitions as well as resourcing the centre with appropriate staff to ensure the wellbeing of residents, the inspection highlighted critical areas requiring improvement. Documentation, review systems, and escalation pathways required strengthened to ensure safeguarding measures fully protect residents. Additionally, compatibility issues and the impact on residents were lacking in safeguarding plans.

As previously highlighted, specific safeguarding concerns were identified in one house accommodating five residents. During a walkaround of the house, inspectors noted that the communal spaces available for residents to relax and engage in

leisure activities were inadequate. The house had one combined kitchen and dining area accessible to residents. While the floor plans and the statement of purpose indicated the presence of a relaxation room, this space was neither appropriately fitted out nor fit for purpose.

The limited communal space was further compounded by the fact that two residents did not enjoy spending time together, a situation expected to be resolved once one resident transitioned to a new home. However, inspectors were not satisfied that, in the interim, the provider had taken reasonable steps to maximise the current living arrangements to ensure the safety and wellbeing of all residents.

In addition to the non-functioning relaxation room, inspectors observed a large office space located off the dining area. When queried about whether the use of this room had been reconsidered in light of the concerns regarding communal space and residents having to retreat to their bedrooms, it was confirmed to the inspectors it had not. This highlighted an opportunity for the provider to re-evaluate the use of available spaces to better meet the needs of residents and address the communal space limitations in the house.

While in the kitchen, the inspector observed a tub of fluid thickener on the counter. When asked about its storage location, staff indicated that these containers were kept in the kitchen cabinets. The inspector brought this to the attention of management, referencing the widely known safety alert regarding such products. The alert emphasises that fluid thickener should not be left within reach of residents, as ingestion of the dry powder poses a choking hazard. A similar issue was observed in another house. By the following day, inspectors were informed that staff had been advised of the correct storage procedures for these products, and all containers had been relocated to appropriate storage areas throughout the campus.

Inspectors reviewed a number of support plans for residents, which outlined steps for staff to follow in the event of behaviours that may negatively impact other residents in the centre. The centre had previously identified compatibility issues between two residents. As part of a support plan, residents were offered options such as going for a walk or spending time in their bedroom to de-escalate situations. However, inspectors noted that the centre had access to several rooms that could be allocated for residents as an alternative to spending time in their bedrooms, promoting greater choice and comfort.

Regulation 17: Premises

Improvements were required to ensure the premises are suitable and appropriately equipped to meet the needs of all residents. The centre's statement of purpose highlighted that two of the houses in the designated centre included relaxation rooms. In the first house, where compatibility concerns had been identified, inspectors were initially unable to locate the relaxation room during a walkthrough. Upon inquiry with the person in charge, inspectors were shown a relaxation room. This room was found to include a single small bean bag, which was visibly stained

and lacked a protective covering. Additionally, the room contained a small sensory fish tank that was out of order and lacked a functioning plug, rendering it unusable.

In the second house, the relaxation room was reviewed and found to be a small space containing a couch. However, inspectors observed that the room was primarily being used for storage, limiting its intended purpose as a relaxation area for residents. Inspectors concluded that the condition and functionality of the relaxation rooms in both houses did not adequately support residents' needs or align with the centre's statement of purpose. Improvements are required to ensure that these spaces are appropriately maintained, equipped, and accessible for residents, thereby promoting their well-being and enhancing the quality of the premises.

Actions from the previous inspection in May of 2024 in relation to a number of works for the premises, had not been completed by the provider. Previous inspection reported highlighted the need for refurbishment to bathrooms in two houses in order to uphold each residents dignity and privacy. The provider had given assurances that work would be completed to these bathrooms in the designated centre by 31 December 2024. However, the identified works had not been completed and no date was set for the commencement of the works. At the time of the inspection the provider had not submitted an updated compliance plan to reflect the delay in works required to the premises.

Judgment: Not compliant

Regulation 26: Risk management procedures

The inspection identified a significant risk management issue concerning the storage of fluid thickener within the designated centre. This practice contravenes established safety alerts, which stress that fluid thickener should not be accessible to residents due to the choking hazard posed by ingesting the dry powder. The same issue was noted in another house within the centre, indicating a broader gap in risk management systems. Inspectors raised this concern with management, emphasising the need for immediate action to mitigate the risk and ensure compliance with safety protocols. Management responded promptly by instructing staff on proper storage procedures and ensuring that all containers of fluid thickener were relocated to appropriate storage areas throughout the campus. While the swift corrective action is acknowledged, this finding highlights a deficiency in the centre's existing risk management framework, particularly in identifying and addressing potential hazards proactively.

Judgment: Not compliant

Regulation 8: Protection

Through a review of documentation and discussions with staff, inspectors identified that improvements were needed to ensure that incidents of a safeguarding nature occurring in the centre were appropriately documented and reviewed. This is to ensure all allegations of abuse involving residents are escalated through the appropriate channels, as required by the provider's policy.

Inspectors reviewed documentation and identified nine separate incidents that occurred in the centre between September 2024 and November 2024. These incidents were not reported as safeguarding concerns and, as a result, were not appropriately screened. Additionally, inspectors found that peer-to-peer allegations of abuse were being documented using behaviour support tools, such as ABC (Antecedent, Behaviour, Consequence) charts. The ABC chart is intended to capture what occurred before, during, and after a behaviour of concern. However, evidence showed that incidents, such as residents being ''upset throughout the day'' due to peer behaviours, were not referred to the provider's designated officer. Furthermore, safeguarding plans had not been updated to reflect the impact of these behaviours on affected residents. These incidents were reviewed only at the local level using the ABC charts.

Inspectors examined formal safeguarding plans for one resident and noted that a safeguarding review had been completed and updated on 14 June 2024. However, incidents recorded in the ABC charts were not included in the safeguarding review because they had not been escalated beyond the local level.

During the review of staff training records, inspectors found that not all staff had completed mandatory refresher training in safeguarding adults at risk of abuse. As of the inspection day, six staff members were overdue for this training.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Centre 4 Cheeverstown House Residential Services OSV-0004927

Inspection ID: MON-0045583

Date of inspection: 13/12/2024

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 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The person in charge will ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuses or allegations of abuse.

Any incident, allegation or suspicion of abuse will be appropriately investigated in line with the Adult Safeguarding policy.

All staff within this Designated Centre will attend a face-to-face training with the social work department to ensure that they are familiar with the reporting processes in safeguarding.

All staff have been provided with the policies aimed at guiding them if they need to raise a concern safeguarding

All audits inclusive of the provider visits in this Designated Centre will be reviewed and actioned in accordance to the audit schedule.

All documentation within this Designated Centre will be reviewed by appropriate qualified personnel.

The person in charge will ensure that there is a schedule of residents meetings in place and that residents have an opportunity to complete Cheeverstown's Satisfaction Survey. All feedback from these surveys will be actioned.

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The Statement of purpose and function will be reviewed to ensure that the information is reflective of the service as set out in Schedule 1.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The person in charge will ensure to give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre any allegation, suspected or confirmed, of abuse of any residents.

Any incident, allegation or suspicion of abuse identified during this inspection will be appropriately investigated in line with the Adult Safeguarding policy and will be notified to HIQA via the portal.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
All works will be completed to ensure accessibility for the residents within this centre to sufficient bathroom facilities and service provider shall ensure adequate private and communal accommodation as set out in Schedule 6.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
An organisational communication patient safety alert advising all staff on the risk of Fluid

thickeners in the event of ingesting this substance and the correct storage has been circulate.

A new tab on the House Risk Registers under health & safety has been completed and a risk assessment has been implemented for same and shared within the organisation for shared learning.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The person in charge will ensure that all safeguarding plans are updated to reflect the impact of incidents that cause distress for the individual.

The person in charge will ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuses or allegations of abuse.

All staff within this Designated Centre will attend a face-to-face training with the social work department to ensure that they are familiar with the reporting processes in safeguarding.

All recording documentation within this Designated Centre will be screened and reviewed by appropriate qualified personnel and any incidents that cause distress will be referred to through our Adult Safeguarding processes.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	31/05/2025
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	31/05/2025
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in	Not Compliant	Orange	31/05/2025

	good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	31/05/2025
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	31/03/2025
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	31/03/2025
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an	Substantially Compliant	Yellow	31/03/2025

	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)(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 care and support provided to residents.	Substantially Compliant	Yellow	31/03/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	28/02/2025
Regulation 03(1)	The registered provider shall prepare in writing	Not Compliant	Orange	28/02/2025

	a statement of purpose containing the information set out in Schedule 1.			
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	28/02/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	28/02/2025
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	28/02/2025
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Not Compliant	Orange	31/03/2025