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:	Hollystown Park - Community Residential Service
Name of provider:	Avista CLG
Address of centre:	Dublin 15
Type of inspection:	Unannounced
Date of inspection:	17 January 2024
Centre ID:	OSV-0008486
Fieldwork ID:	MON-0040883

About the designated centre

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

Hollystown Park CRS is a community based service for four adults with an intellectual disability with medium to high support needs. The centre is a large two storey detached house in a quiet estate in West Dublin. The house is equipped for people with physical disabilities, with residents having ground floor accommodation and access to an adapted vehicle. The house is staffed 24 hours a day by a team of health care assistants and staff nurses. The aim of Hollystown Park is to provide a community-based and person-centred setting wherein persons supported are cared for, supported and valued in an environment that actively supports and promotes their health, development and well-being.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 17 January 2024	09:30hrs to 16:15hrs	Sarah Cronin	Lead

What residents told us and what inspectors observed

From what residents told us and what the inspector observed, it was evident that residents were settling into their new home, and that they were engaging in activities in their communities. However, this inspection had poor findings across a number of regulations which impacted upon residents' care and support in the centre. Improvements were required in governance and management, staff training and development, risk management, safeguarding, complaints, staff training and development and fire precautions. These findings are detailed in the body of the report.

The house is a large two-storey house in a quiet housing estate in west Dublin, and first opened in 2023. The designated centre provides residential care for four adults who have complex health and social care needs. The residents had lived together in another centre within the organisation for many years and moved to enable them to live in a more accessible home. On the ground floor, there is a large sitting room, an accessible bathroom, a large kitchen and dining area and four resident bedrooms. Two of these bedrooms have exits out to the garden. Upstairs comprises an office, a bathroom, a utility room and the staff sleepover room. The premises was found to be clean and warm and had been personalised since a site visit carried out by the inspector in April 2023. Residents' bedrooms had space for their personal belongings, with photographs on display and there was evidence to show that residents' had been involved in choosing the décor for their bedrooms.

Residents in the centre used speech, body language, eye contact, facial expressions and vocalisations to communicate. The inspector had the opportunity to meet with all of the residents over the course of the day and with one family member. On arrival to the centre, some residents were being supported with their morning routines, and two of the residents were waiting to go out to their day service. Residents showed the inspector their bedrooms which were decorated in line with the residents' preferences and reflective of their interests and life stories. One resident showed the inspector their photographs and told the inspector that they liked their new home and later in the day, was observed smiling and joking with staff. Other residents were observed in the sitting room, watching television and engaging in activities they enjoyed such as doing word puzzles. Residents told the inspector that the house was 'better', another described it as 'good' and a third resident spoke about the house being more accessible and said that it was "better 'cause there's no more stair lift for me". One of the residents was able to tell the inspector who they could speak to if they had a concern or a complaint. Interactions between staff and residents were found to be respectful and kind.

In summary, it was evident that residents were being supported to settle into their new home. Residents appeared to be comfortable and content and were well presented. However, there were high levels of non-compliance found on this inspection which impacted negatively upon the quality of residents' care and support. The next two sections of the report present the inspection findings in

relation to governance and management in the centre and how these arrangements impacted upon the quality and safety of residents' care and support.

Capacity and capability

This inspection took place in response to a notification of concern and was the first inspection of this designated centre since it opened in 2023. The inspector found that the governance and management arrangements in the centre were not effective in ensuring adequate oversight of residents' care. This impacted on residents in a number of ways, such as the management of a serious incident, identifying safeguarding concerns, and in ensuring adequate resources to appropriately monitor and oversee key areas of residents' care and support.

A notification of concern had been received in the weeks prior to the inspection. A review of documentation and discussions with management, family and staff indicated that there were inconsistencies in reporting around this incident. This meant that there was a lack of clarity on particular aspects of the incident, and on the care practices which took place before and after the incident of concern. It was evident that senior management had done a critical incident analysis and review, and that a multidisciplinary meeting had taken place where learnings were identified. However, relevant information from these meetings had not yet been shared with the local management team or with the staff team in a timely manner, meaning that key learning and actions to mitigate risks had not been communicated clearly to staff members directly supporting residents. The inspector was informed that a de-brief was due to take place with staff in the weeks after the inspection.

Documentation on the incident was not available to view in the designated centre and held by a member of the management team who was based off-site. This was not in line with regulatory requirements. The policy relating to missing persons which was made available to the inspector did not contain sufficient detail for staff to ensure the resident was appropriately assessed upon their return. It was evident from the review by senior management that there had been poor management practices in the induction of a new member of staff which had negative consequences for residents as a result. A new protocol had been developed to address this gap.

Documentation had gaps across a number of areas which impacted upon the quality of residents' care and support. Areas such as individualised assessments and personal plans, care plans, transition plans and positive behaviour support plans had not been updated for a significant period of time. This meant that residents were not receiving care and support in line with their current assessed needs in their new home.

Auditing in the centre also required improvement to ensure that all areas of residents' care and support were regularly monitored. For example, there had been a number of incidents occur in the centre since it had opened, but an audit of

incidents had not been carried out in over three months. A six-monthly unannounced provider visit had been carried out in the month prior to the inspection. However, this had taken place at night and did not involve consultation with residents or staff. While the report identified some areas for improvement in documentation which found on this inspection, it did not identify concerns relating to safeguarding or risk management.

The person in charge was new to the role of person in charge and was also responsible for another designated centre located approximately twenty minutes away from the centre. They worked on a full-time basis and had roughly half of their hours assigned as supernumerary to fulfill their duties in both houses. They based themselves in the house two to three days each week. It was evident that they had the required skills and competencies to fulfill their role and that they knew residents well. However, due to competing demands of both centres and working shifts in addition to managerial duties, it was evidently difficult to ensure effective day-to-day oversight or monitoring of care and support in the designated centre.

The provider had an appropriate number of staff who had the required skills to meet residents' assessed care and support needs in the centre. There were some vacancies in the centre, which were being covered by agency or relief staff. It was evident that every effort had been made to use the same staff members to enable residents to enjoy continuity of care in their home. Maintenance of rosters required improvement to ensure that the full names of all staff completing shifts in the centre were evident.

The inspector viewed the staff training matrix which showed that all staff had completed mandatory training in safeguarding and fire safety. However, the inspector found that there continued to be gaps in staff training. For example, the provider's compliance plan following the inspector's site visit in April committed to having all staff trained in positive behaviour support, food safety and manual handling by June 2023. This had not yet been achieved.

The provider had a complaints policy in place, however, practice relating to the management of complaints had not been in line with that policy. It was reported to the inspector that there were no complaints in the centre since its opening. However, the inspector found complaints from different parties in minutes of meetings and in progress notes which had not been documented as complaints. Therefore, they were not investigated and managed appropriately. There was little evidence of engagement with the relevant complainants to keep them informed on the actions which the provider was taking to respond to these concerns. This was communicated as an area of concern to the inspector.

Regulation 15: Staffing

Maintenance of rosters required improvement to ensure that the full names of all staff completing shifts in the centre were evident.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Training gaps committed to in the provider's compliance plan from the site visit in 2023 were not yet actioned. For example, there remained gaps in a number of areas such as positive behaviour support, food safety and manual handling, buccal midazolam, feeding, eating, drinking and swallowing and the safe administration of medication. In addition, there were identified training courses which related to residents' assessed needs which included buccal midazolam, feeding, eating, drinking and swallowing, first aid and the safe administration of medication. While it is acknowledged that there were a large number of nursing staff in the centre, health care assistants had not all completed this training. This had been identified as a concern in some staff supervision sessions.

Judgment: Not compliant

Regulation 23: Governance and management

The governance and management arrangements in the centre were found to be ineffective in monitoring and overseeing the quality and safety of the care and support of residents. This was evident across a number of areas relating to the care and support of residents such as the management of serious incidents, identifying areas of concern and ensuring that appropriate actions were taken to address these areas.

Firstly, the inspector was not assured that a recent incident had been managed to ensure that learning was shared with staff within the designated centre in a timely manner to mitigate the risk of reoccurence. Staff and the in-house management were not able to give the inspector clear information on the current status of the review of the incident or what actions were required to mitigate the risk and to continue to provide care and support to the resident in line with their changing needs. Learning from the event had noted that management of staff induction had failed to ensure that residents' care and support needs were communicated, and therefore safely met. A new protocol had been put in place in response to this.

Secondly, documentation was out of date in a number of areas which were central to ensuring that residents' care and support was up-to-date and reflective of their current needs in their new home. For example, transition plans had not been reviewed since the residents move in August 2023, person -centred plans, behaviour support plans, individualised assessments and care plans had not been reviewed. In some cases, person-centred plans and behaviour support plans had not been

reviewed in two years, in spite of incidents occurring.

Finally, while the person in charge had the appropriate level of qualification, experience and skills to fulfill their role, the inspector was not assured that they could have adequate oversight of two designated centres where residents had complex needs in their assigned 19.5 supernumerary hours.

Judgment: Not compliant

Regulation 34: Complaints procedure

As outlined above, the inspector was not assured that the provider had recognised or managed complaints in the centre. Three separate complaints were noted in progress notes and meeting minutes. However, none of these were documented as complaints and therefore, complainants were not responded to in a timely manner.

Judgment: Not compliant

Quality and safety

Residents in the centre were observed to be well presented and supported to engage in activities outside of the centre. They were living in a lovely home which was well suited to their assessed needs. Residents had been consulted with prior to their move into the centre about their preferences for their bedrooms. Bedrooms were highly personalised and residents had ample space to spend time alone, or in the company of others. While the premises was nicely decorated and accessible to residents, gaps were found in safeguarding, fire precautions and risk management.

Staff had received training in safeguarding vulnerable adults. Personal and intimate care plans were suitably detailed to guide staff practice. However, the inspector found that a safeguarding incident which had occured and was witnessed by staff had not been identified or reported in line with national policy. Control measures listed in safeguarding plans had not yet been implemented on the day of the inspection. This meant that safeguarding plans were not effective to manage that identified risk.

While the provider had systems in place for the assessment, management and review of risk which included a system for responding to emergencies, these systems required review to ensure that they were effectively monitoring and responding to risks to residents in the centre. The management of an adverse event in the centre had led to the development of a risk assessment. However, it was not evident that control measures had been implemented or shared with staff. Risk assessments for residents required review to ensure that they were reflective of

their assessed needs. This is further discussed under Regulation 26: Risk Management below.

The provider had fire safety management systems in place in the centre. Fire fighting equipment and emergency lighting and signage was in place. Fire doors were in place and had been repaired following a recent fire drill. However, one door which was located along an escape route had a hold open device which was not working on the day of the inspection. Routine checking of fire safety equipment such as alarms and fire doors was not documented for three separate weeks in the two months before the inspection. Fire drills demonstrated reasonable evacuation times. However, residents' personal emergency evacuation plans (PEEPs) required review to ensure that they contained adequate detail.

Regulation 17: Premises

The inspector found that the premises was designed and laid out to meet the aims and objectives of the service and that it was clean and suitably decorated. The premises was well suited to the residents' assessed needs, with one resident noting this accessibility as a positive outcome for them. There was ample space for residents to store their personal belongings and to spend time alone or in the company of others.

Judgment: Compliant

Regulation 26: Risk management procedures

While the provider had systems in place to identify and manage risk in the centre, the documentation relating to risks pertaining to residents required review to ensure that it was reflective of their current presentation, and that the control measures in place for these risk assessments were being implemented. For example, one resident was at risk of falls. However, the last risk assessment was documented in 2022. Another resident was documented as having a moderate risk in relation to behaviours of concern and there had been incidents occurring in the centre which posed a risk to themselves and others. However, this risk assessment and associated control measures had not been reviewed since their move to their new home. Therefore, the inspector was not assured that all risks were being reviewed in response to incidents, that control measures were actioned and implemented in a timely manner, and as outlined earlier, that key learning from adverse events were shared to mitigate risk in the centre.

While incidents were documented, some of these lacked detail. A review of incidents had not taken place by local management in over three months. This was important to identify trends in the centre and take appropriate actions to ensure control

measures were effective in continuing to mitigate against risk for residents.

Judgment: Not compliant

Regulation 28: Fire precautions

The inspector found three areas relating to fire precautions in the centre which required action. The inspector found that the provider had carried out fire drills which were achieving reasonable evacuation times. However, residents' personal emergency evacuation plans (PEEPs) required an update to ensure that there was clear guidance for staff to follow in the event of an emergency. For example, a new restrictive practice had been put in place, but this was not reflected in residents' personal emergency evacuation plan. For another resident with a diagnosis of epilepsy, information about their emergency medication was not highlighted in their personal emergency evacuation plan.

A number of routine checks of the alarm and fire doors had not been carried out over three weeks in the period of November to January. For example, there were three weeks on the fire register where daily checks of the fire alarm or fire doors were not signed. It was unclear if this was a gap in practice or a gap in documentation. The inspector was not assured therefore that faults would be identified in a timely manner to ensure the ongoing safety of all fire equipment in the centre.

A fire door along an escape route was a swing door which had a hold open device fitted. However, the hold open device was not in working order on the day of the inspection, with the hold open device not meeting the holding magnet on the door frame. This door did not automatically close. This required review.

Judgment: Not compliant

Regulation 8: Protection

The inspector found that a safeguarding concern, which had a negative impact upon a resident, had not been recognised and documented by staff, was not recognised or reported in line with national policy. Furthermore, this had not been identified as a safeguarding issue on incident reviews or audits. This meant that appropriate measures were not put in place at that time, and that engagement took place with the persons involved to mitigate the risk of recurrence. A retrospective notification was sent to the office of the chief inspector following the inspection.

The inspector reviewed safeguarding plans which were in place following some other incidents. Some of the control measures in these plans which were in place to

mitigate risk and ensure safety, remained outstanding for incidents which had occured in the two months prior to the inspection taking place. Therefore, the inspector was not suitably assured that safeguarding incidents were identified by the team, or that appropriate measures were implemented as required.
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	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Hollystown Park - Community Residential Service OSV-0008486

Inspection ID: MON-0040883

Date of inspection: 17/01/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The PIC will ensure the roster is complete and maintained with staff full name, grades of staff, including if relief or agency. The PIC will ensure the Shift leader is clearly identified daily on the planned roster.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All Mandatory trainings has been scheduled and will be completed by the 24.03.2024. The PIC/PPIM will implement a robust system to monitor staff training records that will identify ongoing training needs, thus informing planning and ensuring all staff have completed appropriate training, including refresher training. This system will be monitored at PIC/PPIM meetings.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Service Manager has reviewed the governance arrangements in the centre to ensure that management systems are in place that will ensure the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. The incident was escalated and discussed by the Serious Incident Management Team on 5-12-23 – a review was undertaken by the Service Manager. The Service Manager visited the centre and met the staff team 23/01/2023 and provided an update in relation to the recommendations from the review of the serious incident. Documentation in relation to the incident is maintained by the PIC in the center. There are weekly visits to the centre by the PPIM to ensure enhanced oversight.	

The PIC and PPIM meet weekly to review the progression of actions identified.
Staff Team meetings are scheduled monthly.
All care plans have been audited with identified actions/updates to be completed by the 29.02.2024.
Residents transition plans have been updated.
The PIC and PPIM have reviewed and updated the risk register for the Centre.
Referrals have been forwarded to relevant MDT members.
Staff Induction guidelines have been reviewed and updated. All new staff will be met by a senior manager on their first day of employment.
House guidelines have been updated with necessary information to safely support residents identified needs.
The Provider has ensured additional supernumerary time scheduled for the PIC for a defined period to support implementation of required improvements required in designated centers.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
All complaints have been logged in line with organisations policy on Management of Complaints.
The PIC & PPIM have addressed the identified complaints and have met with the person making the complaints who has confirmed they are satisfied with the outcome of their complaint and is now closed.
The importance of acknowledging and recording complaints has been highlighted with the Staff team.
Complaints are standing agenda item on house meetings with residents and staff team meetings.
A review of complaints is a standing agenda item at PIC/PPIM monthly meetings.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The PIC and PPIM have reviewed all risks in the centre and updated the risk register to ensure it reflects the current risk and an appropriate risk rating is identified. Support was provided by the Quality & Risk Team.
The Provider will ensure that systems are in place whereby all incidents are reported with clarity, that incidents are reviewed by the Manager and PPIM quarterly or sooner where required and that risk assessments and the risk register are reviewed and updated as appropriate to the incident in a timely manner.
The PIC will ensure that incident trends and learning from incidents is shared with staff and discussed at staff team meetings.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
All Personal Emergency Evacuation Plans have been updated to include current

information to support safe evacuation of all residents including information in relation to Restrictive Practice and information regarding emergency medications. Weekly Health and Safety walk around completed and included on the daily shift plan. Daily Fire Checks are also included on Daily Shift Plan. Fire doors have been reviewed by maintenance personnel and are now compliant Fire precautions are standing agenda item for house and staff team meetings. The PPIM is monitoring fire safety systems during weekly visits – this is evidenced in the PPIM log for the centre.

Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: All staff have completed Safeguarding Training. Additional bespoke training has been provided on site by the social work team. Increased awareness in relation to Safeguarding has been raised with the staff team. Safeguarding is a standing agenda item at staff team meetings. All safeguarding incidents were reported as per organisations Policy for the Protection and Welfare of Vulnerable Adults and the Management of Allegations of Abuse. Safeguarding is a standing agenda item at residents' meetings. Current safeguarding plans are in place within individuals' personal plans and were discussed at the team meeting. Safeguarding plans have been reviewed by the MDT 15/02/2024.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	22/01/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	31/05/2024
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	Not Compliant	Orange	15/03/2024

	to residents' needs, consistent and effectively monitored.			
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	15/03/2024
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	30/03/2024
Regulation 28(2)(b)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Not Compliant	Orange	29/02/2024
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and	Substantially Compliant	Yellow	29/02/2024

	extinguishing fires.			
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	29/02/2024
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	29/02/2024
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Not Compliant	Orange	30/03/2024
Regulation 34(3)(a)	The registered provider shall nominate a person, other than the person nominated in paragraph 2(a), to be available to residents to ensure that: all complaints are appropriately responded to.	Not Compliant	Orange	29/02/2024
Regulation 08(3)	The person in charge shall initiate and put in	Not Compliant	Orange	29/02/2024

	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.			