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:	Ladywell Lodge
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Louth
Type of inspection:	Unannounced
Date of inspection:	10 February 2022
Centre ID:	OSV-0003025
Fieldwork ID:	MON-0032943

About the designated centre

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

Ladywell Lodge is a centre situated on a campus based setting in Co. Louth. It provides 24hr residential care to up to eight adult male and female adults some of whom have complex medical needs. The centre is divided into two separate units which are joined by a communal reception area. Each unit comprises of a large dining/sitting room, additional small communal rooms, adequate bathing facilities, laundry facilities and an office. Residents have their own bedrooms. There is a large kitchen shared by both units where residents can prepare small meals and bake. Meals are provided from a centralised kitchen on the campus. Both units have access to a shared garden area where furniture is provided for residents use. The centre is nurse-led meaning that a nurse is on duty 24 hours a day. Health care assistants also play a pivotal role in providing care to residents. The person in charge is responsible for one other designated centre under this provider. They are supported in their role by a clinic nurse manager in order to ensure effective oversight of this centre. Residents are supported to access meaningful day activities by the staff in the centre and have access to a "hub" on the grounds of the campus where they attend some activities. A bus is available in the centre which is shared between the two units to support residents accessing community facilities.

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 10 February 2022	10:30hrs to 18:15hrs	Anna Doyle	Lead
Thursday 10 February 2022	10:30hrs to 18:15hrs	Sarah Barry	Support

What residents told us and what inspectors observed

Overall, the care and support being delivered in the centre by the staff team was to a very good standard. However, as discussed later in this report, the registered provider had not taken timely action to address some areas of service improvements identified through their own audits and complaints. This resulted in significant improvements being required to the premises and the governance and management arrangements. Minor improvements were also required in other regulations as outlined later in this report.

This centre is located on a large campus. The long term plan for this centre is to close and residents will move to purpose built premises or residential homes in the community. The centre was initially designed to accommodate large numbers of residents which was more in keeping with an institution type setting. The centre is divided into two separate areas. However, despite this, since the last inspection a significant amount of work had been done to the premises to create a more cosy, home like environment for the residents living here. This work had been done to a very high standard and had transformed the premises to a more homely environment than that of a large institution. Residents bedrooms had all been redecorated and were finished to a high standard.

Within the centre, there is a centralised kitchen for both units. The inspectors were informed that this was been remodelled to emulate a more home like environment and going forward would be used to prepare residents meals.

Up to now residents meals were being catered from a large centralised kitchen on the campus, which meant that residents did not have the opportunity to experience their meals being cooked in their home. On the day of the inspection, the staff team had planned to cook dinner in the centre. The smells and aromas in the centre were in keeping with a home like ambiance. These changes would have a positive impact for the residents. The clinical nurse manager gave an example of how the staff team wanted to teach the residents the concept of ' from the ground to the table'. This would educate residents about where food comes from. A concept that they had no real significant experience of while living in the campus. On the day of the inspection one of the residents was gone to a garden centre to start buying produce they could start growing to support this initiative.

The inspectors were also informed that the centralised laundry in the centre was closing, this again was moving away from old institutional practices that were common in large campus based settings.

One of the inspectors spoke with two family representatives over the phone to get their views on the services provided. The feedback overall was very positive. Both representatives said that they were kept informed of any changes to the care and support needs of the residents. They were very happy with the support being provided and one spoke about the support they received from staff to ensure that

their family member was able to visit their family home.

They spoke positively about the support their family member received during the COVID-19 restrictions and said that they were supported to see their relative when restrictions were lifted or through video calls when restrictions did not permit visits.

On the day of the inspection a number of residents were out for walks. One resident who liked picking apples was going out shortly after the inspectors arrived in the centre. Their family representative spoke about how this was very important to the resident.

Inspectors met one resident who had moved to the centre since the last inspection from another centre on the campus. This was a temporary measure until suitable community dwellings can be sourced. The staff who worked with the resident had moved here also. This meant that the resident was supported during this transition with staff who knew the resident well. One staff member supporting the resident spoke about the positive changes that were happening for this resident. For example; the staff member informed an inspector that when the resident initially moved to the centre, they spent a lot of their time in a nearby day service facility as they did not engage well with other people in their environment. However, the resident was now choosing to spend most of the day in the centre.The inspectors also observed from this residents' records that since they had moved to the centre, their levels of anxiety had reduced and episodes of behaviours of concern. This was another positive outcome for this resident.

The resident was observed playing a giant sized version of the game ' connect four' and really appeared to enjoy it. There were also plans in place to remodel one of the current rooms in the centre to provide a more sensory experience for this resident.

The clinical nurse manager outlined an ongoing communication assessment that was being completed for all residents. The idea for this assessment was to find how the resident could communicate their needs effectively. The inspectors found that this was really looking at the residents individual needs and already it had been identified that one resident did not react to easy read information in a picture format. The staff team and the speech and language therapist involved was exploring other communication aids to suit the residents needs.

All of the residents looked well cared for. Staff were observed engaging with them in a kind and caring manner. In particular inspectors observed that the residents needs came first and during the inspection staff were observed excusing themselves many times as residents were calling for their attention.

The next two sections of this report present the findings of this inspection in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being provided.

Capacity and capability

Overall, this centre was well managed at a local level by the person in charge and their staff team. However, the registered provider had failed to address a number of ongoing issues in the centre that had been highlighted through audits and complaints. As a result governance and management and the premises were found not complaint. Other improvements were also required in fire safety, records, general welfare and development and policies and procedures.

There was a clearly defined management structure in place, led by a person in charge who provided good leadership and support to their staff team. They knew the residents very well and demonstrated a commitment to improving the lives of the residents living here. They were employed on a full time basis, but were also responsible for another designated centre under this provider. In order to ensure effective oversight of the centre a clinical nurse manager was employed to support the person in charge with the oversight arrangements. The clinical nurse manager facilitated some of the inspection, they too demonstrated a very good knowledge of the residents' needs and provided a number of examples as discussed earlier in the report about how they were improving the lives of the residents living here.

The person in charge reported to a director of care and support, who was also a person participating in the management of the centre. They met regularly to discuss the care and support provided.

However, despite this and as stated earlier the governance and management arrangements in the centre needed significant improvements to ensure that complaints were acted on in a timely manner and areas of improvement highlighted through the providers own audits were addressed. The inspectors viewed a number of complaints in the centre where, family, staff and residents had complained about the outside pathways being uneven and dangerous. These complaints had been raised initially in 2019 and to date limited actions had been taken to address this. The person in charge had also conducted an infection control audit in the centre in June 2021 which highlighted a number of issues that needed to be addressed. While they had been reported to senior managers, a number of the issues had not been addressed. For example; it had been highlighted that the front door would not fully open in certain weather conditions. This had not been addressed at the time of the inspection.

There was sufficient staff in place to meet the needs of the residents. A number of regular relief staff were also employed to ensure that residents received consistent care when staff were on planned or unplanned leave. During the day six staff were on duty; and at night three staff were employed. At least one nurse was rostered on duty for each shift, which meant that residents had nursing care available to them where required. A senior nurse was also on call 24/7 should staff require additional supports.

Staff met said that they felt very supported in their role and were able to raise concerns, if needed, to a manager on a daily basis. A sample of staff personnel files reviewed were found to contain the information required under the regulations. For

example; Garda vetting was in place for staff.

The training records showed that staff were provided with training to ensure they had the necessary skills to respond to the needs of the residents. This included basic life support, safeguarding adults, fire safety, manual handling, supporting residents with dysphagia and infection prevention and control. However, a number of staff required refresher training in basic life support, manual handling, behaviour support and fire safety.

A review of incidents the had occurred in the centre over the last year, informed inspectors that the person in charge had notified the Health Information and Quality Authority (HIQA) as required under the regulations.

The provider maintained a copy of the policies and procedures required under the regulations to be available in the centre. A sample of the policies viewed had been reviewed every three years as required under the regulation with one exception. The policy on the creation of, access to, retention of, maintenance of and destruction of records should have been revised in May 2019 and this was not done.

Regulation 14: Persons in charge

The person in charge provided good leadership and support to their staff team. They knew the residents very well and demonstrated a commitment to improving the lives of the residents living here. They were employed on a full time basis, but were also responsible for another designated centre under this provider. In order to ensure effective oversight of the centre a clinical nurse manager was employed to support the person in charge with the oversight arrangements.

Judgment: Compliant

Regulation 15: Staffing

There was sufficient staff in place to meet the needs of the residents. A number of regular relief staff were also employed to ensure that residents received consistent care when staff were on planned or unplanned leave.

A sample of staff personnel files reviewed were found to contain the information required under the regulations. For example; Garda vetting was in place for staff.

Judgment: Compliant

Regulation 16: Training and staff development

A number of staff required refresher training in basic life support, manual handling, behaviour support and fire safety.

Judgment: Substantially compliant

Regulation 21: Records

Records stored in the centre required review as identified through the providers own audits.

The provider had a local policy in place to maintain records relating to daily transport checks in the centre. Not all of these records were available on the day of the inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

The governance and management arrangements in the centre needed significant improvements to ensure that complaints were acted on in a timely manner and areas of improvement highlighted through the providers own audits were addressed.

Judgment: Not compliant

Regulation 3: Statement of purpose

The Statement of Purpose contained all of the requirements of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

A review of incidents the had occurred in the centre over the last year, informed inspectors that the person in charge had notified the Health Information and Quality

Authority as required under the regulations.

Judgment: Compliant

Regulation 4: Written policies and procedures

The policy on the creation of, access to, retention of, maintenance of and destruction of records should have been revised in May 2019 and this was not done.

Judgment: Substantially compliant

Quality and safety

Overall, the residents here were receiving good standards of care in terms of their health care needs. A number of initiatives were underway to enhance the resident's quality of life and provide the residents with valued social roles. Other projects were also planned to remodel the kitchen so as all meals could be prepared in the resident's home and residents could experience this and contribute to cooking and preparing meals if they wished. Notwithstanding, some improvements were required to the premises, residents access to activities and fire safety.

As stated the property was for the most part clean and spacious and most of the rooms had been redecorated to a very high standard since the last inspection. However, some areas needed attention as identified through the providers own audits. For example; the grout around tiles and one hand basin needed to be redone. The external pathways needed to be addressed as discussed earlier in this report.

Inspectors also observed that most of the windows in the residents' bedrooms needed to be cleaned, repainted and repaired.

Resident were supported to have meaningful activities during the day. Each resident had a timetable outlining the activities they planned for each day. The person in charge and staff team had started putting measures in place to try and improve some of these activities. For example; they were seeking ways to provide residents with valued social roles. One resident was starting to grow some vegetables in a small area at the back of the centre. These vegetables, when ready would be used to prepare meals for all of the residents. However, one resident who liked swimming had not attended this for many months. This needed to be reviewed.

Personal plans were in place for all residents, which included a detailed assessment of need which had recently been updated. Detailed support plans were also in place to guide staff practice. These plans were also reviewed regularly to ensure that the

care and support was being delivered in a timely and effective manner. An annual review had been conducted with the resident, the staff team and some allied health care professionals. The family members spoken with confirmed that they were invited to attend these reviews; and that where they could not attend their views or suggestions were included at the review meeting.

Residents health care needs were supported very well in the centre. They had timely access to a range of allied health professionals and were supported by staff to attend all health care appointments. Where required residents had been provided access to national health screening programmes.

Residents were supported to have best possible mental health. Where required they had the support of behaviour specialists. Positive behaviour support plans were devised to guide staff practice. One staff who supported a resident in this area, knew the residents needs very well.

There were systems in place to manage and mitigate risk in the centre. This included a risk register for overall risks in the centre and individual risk assessments for residents as required. Incidents in the centre were reviewed regularly and any actions agreed to mitigate risks had been implemented. There were two vehicles available in the centre. One of the vehicles was not in use at the time of the inspection as it was awaiting a road worthiness test. The other vehicle was insured and had a certificate to demonstrate that it was in a road worthy condition.

Fire safety systems were also in place and the person in charge had highlighted that some of these systems needed to be reviewed to ensure a safe evacuation of the centre. As a result the provider had engaged the services of a qualified fire person to review the systems in place and fire evacuation procedures. This report was not finalised at the time of the inspection. As a result inspectors could not be assured that the fire evacuation procedures in the centre were effective.

All staff had been provided with training in safeguarding vulnerable adults. Of the staff met, they were aware of the procedures to follow in the event of any concerns around the well being of residents.

Infection control measures were also in place to manage/prevent an outbreak of COVID-19. Staff had been provided with training in infection prevention control and donning and doffing of personal protective equipment (PPE). There were adequate supplies of PPE available in the centre. This was being used in line with national guidelines. There were adequate hand-washing facilities and hand sanitising gels.There were measures in place to ensure that both staff and residents were monitored for possible symptoms. Increased cleaning schedules were in place and since the last inspection a new staff who was responsible for cleaning the centre had been employed.

Inspectors found examples of where residents' rights were being upheld and promoted in the centre. For example; the staff team were assessing and reviewing residents individual communication styles which would enable them to be informed and included more in decision making.

Regulation 13: General welfare and development

One resident who liked swimming had not attended this for many months. This needed to be reviewed.

Judgment: Substantially compliant

Regulation 17: Premises

Some areas in the premises needed attention as identified through the providers own audits. For example; the grout around tiles and one hand basin needed to be redone.

The external pathways needed to be addressed as discussed earlier in this report.

Inspectors observed that most of the windows in the residents' bedrooms needed to be cleaned, repainted and repaired.

Judgment: Not compliant

Regulation 26: Risk management procedures

There were systems in place to manage and mitigate risk in the centre. This included a risk register for overall risks in the centre and individual risk assessments for residents as required.

There were two vehicles available in the centre. One of the vehicles was not in use at the time of the inspection as it was awaiting a road worthiness test. The other vehicle was insured and had a certificate to demonstrate that it was in a road worthy condition.

Judgment: Compliant

Regulation 27: Protection against infection

Infection control measures were also in place to manage/prevent an outbreak of COVID-19. Staff had been provided with training in infection prevention control and donning and doffing of personal protective equipment (PPE). There were adequate

supplies of PPE available in the centre. This was being used in line with national guidelines.

Judgment: Compliant

Regulation 28: Fire precautions

Fire safety systems were also in place and the person in charge had highlighted that some of these systems needed to be reviewed to ensure a safe evacuation of the centre. As a result the provider had engaged the services of a qualified fire person to review the systems in place and fire evacuation procedures. This report was not finalised at the time of the inspection. As a result inspectors could not be assured that the fire evacuation procedures in the centre were effective.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Personal plans were in place for all residents, which included a detailed assessment of need which had recently been updated. Detailed support plans were also in place to guide staff practice. These plans were also reviewed regularly to ensure that the care and support was being delivered in a timely and effective manner. An annual review had been conducted with the resident, the staff team and some allied health care professionals.

Judgment: Compliant

Regulation 6: Health care

Residents health care needs were supported very well in the centre. They had timely access to a range of allied health professionals and were supported by staff to attend all health care appointments. Where required residents had been provided access to national health screening programmes.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents were supported to have best possible mental health. Where required they had the support of behaviour specialists. Positive behaviour support plans were devised to guide staff practice. One staff spoken to who supported a resident in this area, knew the residents needs very well.

Judgment: Compliant

Regulation 8: Protection

All staff had been provided with training in safeguarding vulnerable adults. Of the staff met, they were aware of the procedures to follow in the event of any concerns around the well being of residents.

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors found examples of where residents' rights were being upheld and promoted in the centre. For example; the staff team were assessing and reviewing residents individual communication styles which would enable them to be informed and included more in decision making.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Ladywell Lodge OSV-0003025

Inspection ID: MON-0032943

Date of inspection: 10/02/2022

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Staff requiring refresher training for basic life support, manual handling, behaviour support and fire safety, have been identified. The respective staff have been booked to attend upcoming training sessions as per availabilities on the training calendar. The house manager and Person in Charge are monitoring staff training as part of roster planning for the designated centre.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Records identified as part of the internal auditing for the house are being updated and completion of these will be reflected on the quality enhancement plan for the designated centre. The checklist for transport has been updated to reflect the necessary driver's checks that need to be carried out prior to using transport. These were also updated to include a cleaning schedule record as part infection prevention and control. The archive record books are maintained by the Person in Charge.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
All outstanding complaints have being reviewed by the Person in Charge & the PPIM.

Outstanding internal works identified through internal audits have being identified and have been referred to the maintenance department for completion.

There is a system in place for escalating items that need repair through the maintenance department.

The house manager and Person in Charge will conduct a weekly walk about to identify items that require attention and highlight these to the maintenance department.

These works will be monitored by the Person in Charge & PPPIM through the weekly reviewing of the quality enhancement plan for the designated centre.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The Orders policy on retention of records is being reviewed at present and is in draft format, last draft is dated 07/02/2022.

Once this policy is finalised it will be circulated to all, by the Persons in Charge

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 resident person centre plan has been updated to reflect a weekly swimming schedule as part of resident's goals setting.

This schedule will also include all social activities the resident enjoys.
Goals setting and achievements will be monitored by the house manager and Person in Charge, though the resident's person centred planning process.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Register Provider will review the external pathways outside the Designated centre with review to repairing them to support residents to access some of the outside areas.

Outstanding internal works identified through audits have being identified and have been referred to the maintenance department for completion.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The Person in Charge has reviewed all the fire safety systems within the Designated centre. The Person in Charge is engaging with the local fire department to reacquaint themselves with the layout of the designated centre and on site education for residents and staff support team.

The emergency evacuation plan is being updated to reflect horizontal fire evacuation throughout the building and to provide more details with respect to compartmentalising within the designated centre.

The findings within the fire safety report are being referred to an external quantity surveyor for costings and a plan for completion will devised following this.

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 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Substantially Compliant	Yellow	30/05/2022
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.	Substantially Compliant	Yellow	30/07/2022
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	30/07/2022
Regulation	The registered	Substantially	Yellow	30/05/2022

21(1)(b)	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.	Compliant		
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	30/05/2022
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	30/05/2022
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	30/05/2022
Regulation 04(3)	The registered provider shall review the policies	Substantially Compliant	Yellow	30/08/2022

	and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			