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:	Shalom
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	12 April 2023
Centre ID:	OSV-0004873
Fieldwork ID:	MON-0038027

About the designated centre

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

Shalom is a residential service operated by Brothers of Charity Services Ireland. The centre is located on the outskirts of a town in Co. Clare and transport is provided. A maximum of three adults attend the service. One resident receives a full-time residential service and two residents attend the centre on a shared care basis. The support provided is designed to meet a broad range of needs and a staffing presence is maintained in the house at all times. Staffing levels fluctuate in response to the occupancy and the needs and wishes of residents. The service is operated from a bungalow type dwelling with residents having their own bedroom, along with access to a communal bathroom, one en-suite facility, kitchen and dining area, sitting room, patio and a large garden area. The model of care is social and the staff team is comprised of support workers with day to day management responsibilities assigned to the person in charge supported by a social care worker.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 12 April 2023	10:30hrs to 17:15hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was undertaken by the Health Information and Quality Authority (HIQA) to follow up on the findings of the previous HIQA inspection completed in February 2022 and the actions the provider said it would take to improve the quality and safety of the service. This inspection found that while not fully resolved, the actions taken by the provider had improved the quality and safety of the service for residents and staff.

For example, on arrival at the centre the inspector saw that the planned extension of the premises while not at the original hoped for stage of completion was in progress. This main house was not impacted by these works and the house was visibly very clean and tidy. Staff members on duty were aware of the most recently revised infection prevention and control guidance.

There was one resident at home. The assessed needs of the resident included communication differences and while the resident was not able to tell the inspector what life was like for them in this centre, the resident looked well and happy and presented as content to be with the staff members on duty. The resident maintained good eye contact with the inspector and took some time to observe and satisfy themselves that they were happy for the inspector to be in their home. The resident smiled, gave a thumbs up when asked how they were and followed the inspector with interest around the house for a short period of time.

The resident spent most of the day out and about with a staff member and staff told the inspector that the resident was always happy to be out in the community. There was some evidence however, that until the premises extension was complete there was still a requirement to manage the occupancy of the service and the routines of residents given their different needs and preferences.

For example, the service was now delivered so that a maximum of two residents were generally present in the house. Two residents in particular needed their own space but they shared the communal areas of the house. The provider had since the previous HIQA inspection enhanced the staffing levels in the centre in response to the risk created by differing resident needs and circumstances. The staff and management members spoken with reported positive impacts for residents and staff. For example, these staffing levels supported individualised routines for residents and reduced the amount of time that staff members lone worked in the service. However, the provider had an open business case submitted to their funding body in relation to extending the current shared care arrangement of one resident and the additional staffing that was needed for this.

A second resident arrived in the evening to start their shared care visit. The resident did not express any particular interest in the presence of the inspector. The resident was focused on their planned activity for the evening and the arrival of their support worker so that they could leave the house as planned. The resident was clearly

comfortable with the staff members on duty and was well able to manage aspects of their routine. For example, the resident entered the staff office to collect the items that they needed for their planned community activity.

The person in charge was in the process of reviewing each resident's personal plan in consultation with residents, their representatives and the staff team. Records seen indicated a good variety of activities that residents enjoyed such as going to the cinema, going bowling, going to mass, attending local events and enjoying nights away supported by staff.

While residents did not provide explicit feedback to the inspector and the inspector did not meet with any resident representative, there was recent feedback on file from both residents and representatives. Staff members had supported residents to provide their feedback. This feedback reflected the knowledge that staff had of each resident and their particular needs and choices. Staff described how residents were supported to exercise their choices. For example, how a resident might use gestures to express a particular meal preference and the use of a visual weekly planner with another resident. However, staff had also captured the challenges that still arose for residents due to their differing needs and preferences. The feedback provided by residents' representatives was positive. Where improvements were suggested these were included in the service quality improvement plan. The provider had also since the last HIQA inspection established a formal communication framework. However, there was still some improvement needed in the monitoring of the management of complaints.

There were no reported restrictions on visits. Two residents attended the service on a shared care basis and spent part of each week at home with family. Staff maintained a record of any engagement they had with families.

In summary, these inspection findings reflected a much more relaxed service due to the improved systems put in place and the definitive actions taken by the provider. Good daily monitoring and oversight was maintained of the service by the person in charge in consultation with their manager. The provider responded to any concerns arising about the quality and safety of the service. However, there were resident needs and preferences that were not compatible and this required active management. An additional control in response to the impact of these differing needs was the extension to the house that was in progress. While there was good solid practice evidenced, some improvement was needed so that there was a clear link between the management of risk, the monitoring of incidents and other areas of support such as positive behaviour support.

The next two sections of this report will present the findings of this inspection in relation to the governance and management of the service and how governance and management affected the quality and safety of the service being delivered.

Capacity and capability

As referred to in the opening section of this report the provider had since the last HIQA inspection of this service, reviewed and amended some of its systems and arrangements. Though not fully resolved, these changes had, based on these inspection findings, improved the quality and safety of the service for residents and staff.

For example, the provider had reviewed and amended the planning and operation of the service. This meant the residents whose needs and preferences were not compatible spent less time together in the service. In conjunction with these changes the provider had additional staff on duty for times when residents were in the service together. These increased staffing levels meant that risk to residents and staff was more appropriately avoided, managed and responded to. The staff rota reflected the staffing levels and arrangements described and observed. For example, there were days when there were three staff members on duty from 09:00hrs to 21:30hrs. However, the provider did have an open business case seeking funding for the additional staffing that was needed so that the service provided to one resident would be provided as requested.

The person in charge was based in the house and described to the inspector how this meant they could directly monitor and supervise the care and support provided each day by the staff team. For example, the person in charge described the monitoring of the implementation of behaviour support strategies. The person in charge was supported by a social care worker and had access as needed to their line manager.

The person in charge convened monthly staff team meetings where each resident's needs and support and other matters such as incidents were discussed with the staff team. Good oversight was maintained of staff attendance at staff training. The staff duty rota was well presented and maintained.

Formal systems of oversight included the monthly analysis of incidents that occurred and the completion of reviews such as the annual and six-monthly reviews of the quality and safety of the service as required by the regulations. As discussed in the opening section of this report residents were meaningfully supported to contribute to the annual review.

The six-monthly reviews were completed on schedule and most recently in November 2022. That review was comprehensive, was focused on the quality and safety of the service and the specific matters arising in this service such as the risk posed by the incompatibility of resident needs and how this was responded to. Based on these HIQA inspection findings there was improvement in the quality and safety of the service since that review was completed and good progress was being made on the implementation of the quality improvement plan. However, some improvement was still needed such as in risk management and complaint management. These improvements are addressed in this report in the relevant regulations.

Regulation 14: Persons in charge

The person in charge had the skills, qualifications and experience needed for the role. The person in charge had other areas of responsibility but was satisfied that they had the capacity and the supports in place to ensure the effective management and oversight of the service. For example, the person in charge had practical support from a social care worker and had access as needed to their line manager who was also based locally. The person in charge had solid knowledge of the operation of the service and of each resident, their needs and supports indicating the person in charge was consistently engaged in the management and oversight of the service.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels and arrangements had been reviewed and increased since the last HIQA inspection so as to better meet the assessed needs and preferences of each resident. However, based on the assessed needs of residents and the established incompatibility of some resident needs, additional staffing was needed to facilitate a request received to extend one shared care arrangement. The provider had an open business case submitted to its funding body in this regard.

Judgment: Substantially compliant

Regulation 16: Training and staff development

A record was maintained of the training completed by each staff member. This included mandatory training such as training in fire safety, manual handling and safeguarding and, required training such as in the management of medicines and infection prevention and control. Consistent oversight was maintained of this training and refresher training that was due was scheduled or planned. Additional completed and planned training included training in falls prevention and working with residents to agree their personal objectives. The person in charge provided examples of how they supervised staff and staff practice and confirmed that formal staff supervisions were completed in line with the providers supervision policy.

Judgment: Compliant

Regulation 23: Governance and management

While quality and safety issues were not fully resolved, the provider had taken meaningful and measurable actions to improve the quality and safety of this service. The provider had reviewed its capacity to provide each resident with a safe quality service and had made changes to the service it provided further to this review. The provider had reviewed and increased the staffing levels and arrangements in this service. There was a clearly defined management structure and clearly defined responsibilities which meant that matters such as staffing matters and risks were addressed at the appropriate level of the management structure. Good daily monitoring and oversight was maintained of the service by the person in charge supported by a social care worker and in consultation with their manager. The provider had allocated resources so that residents would be provided with the facilities that they needed and a safer home. Overall, the provider was effectively collecting and using data to monitor and improve the service. Some improvement was needed in this regard such as in consistently demonstrating how the findings from the analysis of incidents was used to assure or improve practice such as behaviour support. This is addressed in the relevant regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure was displayed in the main hall. There was one documented complaint of file. However, while the complaint was deemed to have been satisfactorily resolved there was no recorded follow-up with the complainant to assure their ongoing satisfaction. This follow-up was stipulated in the complaint record.

Judgment: Substantially compliant

Quality and safety

There were resident needs and preferences that were not compatible. While not fully resolved the actions taken by the provider (as described in the last section of this report) had improved the appropriateness, quality and safety of the service.

For example, staff spoken with described how the improved staffing levels and arrangements meant that attending to the needs of one resident did not impact on the support needed by another resident. This had been identified as a trigger for responsive behaviours of concern. These improved staffing levels and arrangements

and suitable transport arrangements, meant that each resident had the staff support that they needed and had good opportunity to be out and about in the community supported by staff.

The person in charge was in the process of reviewing and updating each resident's personal plan and transferring the plan onto the new Personal Outcomes Measures (POM) format. The person in charge used the narrative notes created each day by staff as a tool to monitor the implementation of the personal plan and the quality of the opportunities for engagement provided to each resident. The narrative notes reviewed by the inspector were comprehensive and respectful of the needs and wishes of each resident. However, the completion of the extension to the premises was an outstanding control to ensure the provider had in place, the arrangements needed by each resident.

It was evident from speaking with the person in charge and records seen that members of the multi-disciplinary team (MDT) inputted into and, their recommendations informed the care and support provided by staff. For example, the resident's general practitioner (GP), psychiatry, and the behaviour support team. There was evidence that the latter was currently engaging with the staff team and staff were maintaining records of any behaviours and incidents that occurred. However, this input and any changes made were not clearly evident from the positive behaviour support plan.

A range of restrictive practices were in use. There was a risk assessment in place outlining the rationale for their use and, their ongoing use was reviewed in line with the providers own policy and procedures.

Incidents including behaviour related incidents did still occur. These incidents and their management were reviewed as they occurred and were also analysed on a monthly basis by the person in charge to identify any patterns or trends. However, while possible triggers were identified by this analysis the pathway of learning, change or any improvement needed was not consistently evidenced. For example, the number, type and intensity of incidents that occurred was not consistently referenced when risk assessments were reviewed.

Regulation 10: Communication

The personal plan detailed the communication abilities and styles of each resident. Staff described how a resident could use purposeful words or gestures to express their choices and preferences. For example, on the morning of inspection the resident had clearly demonstrated through gesture what their preferred breakfast option was. Residents also at times used behaviour to express how they felt or how they perceived a certain situation. The analysis of incidents completed by the person in charge indicated that communication was a possible trigger for behaviour such as when staff members asked the resident to do something. This information needed to be more closely linked to the review of the positive behaviour support plan and communication strategies. This is addressed in Regulation 7: Positive behavioural

support.

Judgment: Compliant

Regulation 11: Visits

There were no reported restrictions on visits. The wellbeing of visitors was ascertained so as to reduce the risk of accidentally introducing infection to the service. Two residents had access to home and family each week as they attended the service on a shared care basis. Family were updated by staff in relation to any changes that occurred and were invited to participate in the review of the personal plan.

Judgment: Compliant

Regulation 13: General welfare and development

Each resident had opportunities to engage in a range of activities that were, based on the available evidence, suited to their interests and capacities. The person in charge was in the process of reviewing and identifying each resident's personal objectives for the coming year. Staff spoken with described how the increased staffing levels had improved the opportunities available to residents as residents had one-to-one or two-to-one staff support up to 21:30hrs. The range of community based activities enjoyed included going to the cinema, meeting peers, attending local music events and dances and enjoying trips to various amenities supported by staff. Residents were supported to maintain personal relationships.

Judgment: Compliant

Regulation 18: Food and nutrition

Based on the records seen residents could and did choose their preferred meals. Staff maintained a record of the meals and snacks provided and these records indicated a good variety of meals. Where there were specific dietary requirements records of clinical reviews such as speech and language therapy were in place. Staff maintained monitoring records such as of a residents' daily fluid intake.

Judgment: Compliant

Regulation 26: Risk management procedures

The risks identified and the controls put in place by the provider were specific to the centre and to each resident. However, while risk assessments were regularly reviewed, the assessed residual risk rating did not consistently reflect the occurrence of incidents, the effectiveness of existing controls or, the need for additional controls. For example, the risk rating for evacuation in the event of fire was low despite a repeat pattern of one resident not engaging with their current PEEP. A better link was needed between the review of incidents and the review of the associated risk assessments as it was somewhat inconsistent. For example, the review of the risk for behaviour that challenged or the risk for aggression and violence was not clearly linked to the occurrence of incidents or the impact of the implemented controls. A better link was needed between the generic risk assessments and risk assessments as they pertained to each resident where the same risk was being assessed. The analysis of incidents was regular and findings were concluded. However, how these findings were used to review, inform and improve as needed other areas of practice such as specific healthcare plans or behaviour support plans was not clear.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The premises was fitted with the required fire safety measures such as a fire detection and alarm system, emergency lighting and doors with self-closing devices designed to contain fire and its products such as smoke. All staff had completed fire safety training and participated in regular simulated evacuation drills. There was a risk that one resident may not co-operate with the evacuation procedure. This was specified in the resident's personal emergency evacuation plan (PEEP) as were the prompts to be used by staff to encourage the resident to evacuate. However, recent simulated drills had shown that the resident was not engaging with these prompts. The person in charge was aware of this and the need for additional controls such as site specific fire training.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Since the last HIQA inspection it had been established by way of external review that there was an absence of compatibility between residents' needs and preferences. The provider had implemented many elements of it's improvement plan. However, while matters had improved, staff had recently recorded how one

resident preferred to have the house to themselves and another resident disliked the noise levels that arose in the house at times. There was evidence of routines and strategies to reduce the amount of time that residents spent together in the house to prevent the occurrence of behaviour that challenged. These strategies reduced the level of service that was provided and had the potential to impact on the level of choice and control that each resident had. For example, the choice to stay at home in the house rather than going out. The extension of the premises was in progress but it was behind schedule due to matters outside of the providers control.

Judgment: Substantially compliant

Regulation 6: Health care

It was evident from records seen and staff spoken with that staff monitored resident well-being and sought advice and care for residents as needed and to promote their good health. The person in charge in consultation with representatives as appropriate ensured that residents had access to the clinicians and services that they needed for their ongoing health and wellbeing. For example, residents attended the dentist, had regular chiropody and attended their general practitioner (GP) for routine monitoring and to receive for example, vaccinations to protect them from infections such as COVID-19. The oversight of resident health and wellbeing included the review of any prescribed medicines and their effectiveness. As discussed above in Regulation 26 better correlation was needed between the analysis of incidents and other areas of support including healthcare so as to assure the care that was provided. For example, the effectiveness of the current elimination plan.

Judgment: Compliant

Regulation 7: Positive behavioural support

There was evidence that the support provided was informed by input from the behaviour support team. For example, staff were collating records of incidents to be submitted and analysed by the behaviour support team. However, one positive behaviour support plan was dated 2021 and while another plan was dated as reviewed in February 2023 there were actually two plans available to staff and a third undated standalone document that outlined staff response strategies to different behaviour scenarios. Therefore the accuracy of the most up-to-date interventions was unclear. Better correlation was needed between the findings of the analysis of incidents completed by the person in charge and the positive behaviour support plan. In particular, the role of communication between staff and residents as a possible trigger for behaviour.

Judgment: Substantially compliant

Regulation 8: Protection

The provider responded to and investigated any concerns that arose about the safety of the service provided to residents. All staff had completed safeguarding training and this training had reverted to face-to-face training facilitated by the designated safeguarding officer. The designated safeguarding officer met with staff and residents as needed and monitored the ongoing requirement for safeguarding plans. Staff sought to develop resident understanding of how to stay safe. The person in charge said that each resident understood the difference between right and wrong and could communicate this in their own way.

Judgment: Compliant

Regulation 9: Residents' rights

The corrective actions taken by the provider and the changes made to the way in which the service operated reflected, recognised and promoted each residents right to a service that was safe and responsive to their individual needs and circumstances. Staff spoken with described how, despite communication differences residents expressed their choices and preferences. Different strategies worked for different residents. For example, one resident had a planner that was planned and agreed in advance while another resident needed a more flexible approach to their daily routine, plans and choices. Staff convened monthly resident meetings and two residents were reported to engage with this process. Where their religious beliefs were important to them residents were supported to exercise their beliefs such as regularly attending mass.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Shalom OSV-0004873

Inspection ID: MON-0038027

Date of inspection: 12/04/2023

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 has submitted a business case to the HSE for an upgraded residential service for a resident. We are currently awaiting approval for this proposal. (Planned completion: 31.07.23)	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The complaints officer has taken the necessary steps to follow up with the complainant in relation to their complaint. A record has been made to document the details of the follow-up. (Completed on 05.05.2023)	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The Person in Charge will ensure all risks are regularly reviewed and updated to ensure they remain relevant and effective in addressing emerging risks. (Planned Completion: 31.05.2023)	

The Person in Charge will work closely with the team and multi-disciplinary team to identify and prioritize risks, and to develop and implement appropriate risk management strategies.
(Planned Completion: 31.05.2023)

Monthly reviews/ analysis of incidents are carried out; risk assessments will be reviewed in coordination with this plan. (Planned Completion: 31.05.2023)

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The extension of the premises is in progress. It is planned that the works in the center will be completed by September 2023. (Planned completion: 30.09.2023).

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The PIC will ensure Positive behavior support plans are reviewed by PBS specialist at least annually. (Planned Completion: 31.05.2023)

The PIC will ensure behaviour support plans are in place to help staff manage residents' behaviours. Positive behaviour support plans will be updated regularly and incorporate the findings from the analysis of incidents.
(Planned completion: 31.05.2023)

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	31/07/2023
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	Substantially Compliant	Yellow	31/05/2023

	emergencies.			
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Substantially Compliant	Yellow	05/05/2023
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	30/09/2023
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Substantially Compliant	Yellow	31/05/2023
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's	Substantially Compliant	Yellow	31/05/2023

	challenging behaviour.			