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:	Country Lodge
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Short Notice Announced
Date of inspection:	12 August 2021
Centre ID:	OSV-0005827
Fieldwork ID:	MON-0033673

About the designated centre

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

Country Lodge is a designated centre operated by Saint Patrick's Centre (Kilkenny). It provides a community residential service for up to four adults with a disability and complex needs. The designated centre is a detached bungalow which comprises of four individual resident bedrooms, an office, a visitors room, a large open planned kitchen/dining/living room and a number of shared bathrooms. The designated centre is located close to an urban area in County Kilkenny near to local amenities and facilities. The staff team consists of staff nurses, social care workers and health care assistants. The core staff team is supported by the person in charge.

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 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 12 August 2021	10:10hrs to 17:20hrs	Conan O'Hara	Lead

What residents told us and what inspectors observed

This inspection took place during the COVID-19 pandemic. As such, the inspector followed public health guidance and HIQA enhanced COVID-19 inspection methodology at all times. The inspector carried out the inspection primarily from the visitors room of the designated centre. The inspector ensured physical distancing measures and the use of personal protective equipment (PPE) were implemented during interactions with the residents, staff team and management over the course of this inspection.

Overall, from what residents communicated with the inspector and what the inspector observed, it was evident that the residents received a good quality of care in the designated centre. The inspector had the opportunity to meet with the four residents of the designated centre during the course of the inspection, albeit this time was limited. Residents were observed and overheard going about their day and appeared content in the presence of staff and in their home. The residents in this centre did not communicate verbally and communicated through vocalisations, facial expressions and movement. Staff were observed as being very responsive to the residents. All of the interactions observed were caring and person centred. It was evident that the residents and staff were comfortable in each others company

On arrival to the centre, the inspector observed one resident arriving back to the centre after a morning drive and another resident interacting with staff and enjoying music in the living area. The third resident was being supported to get ready for the day and was later observed making their way to the kitchen table for their breakfast. The fourth resident was enjoying a lie in. Later in the morning a musician arrived from the Community Hub to play music with the residents.

In the afternoon, residents were observed enjoying watching TV, interacting with another and the staff team. Two residents were observed to go shopping in the community with support from staff while one resident was observed independently spending time as desired between the house and the front yard.

The designated centre is a detached bungalow which comprises of four individual resident bedrooms, an office, a visitors room, a large open planned kitchen/dining/living room and a number of shared bathrooms. The inspector was informed that this building is a temporary premises for the four residents while the provider was in the process of building a purpose-built house.

Overall, the centre was well maintained and decorated in a homely manner with personal possessions, pictures of the residents and people important in their lives throughout the centre. The centre was wheelchair accessible throughout, apart from the double door leading from a bedroom to the garden. This had been identified on the previous inspection. The inspector was informed that a business case had been submitted to address this and at the time of the inspection it remained in progress. The centre contained required aids and appliances to assist residents with mobility

and personal care needs such as overhead hoists. However, some improvement was required in the storage. For example, the inspector observed a number of supportive equipment being stored in the office, bathroom and bedrooms of the centre. This had been self-identified by the provider.

In summary, based on what the residents communicated with the inspector and what was observed, it was evident that residents received a good quality of care. However, there are some areas for improvement including staffing arrangements, premises, personal plans and fire safety. The next two sections of the report present the findings of this inspection in relation to the the overall management of the centre and how the arrangements in place impacted on the quality and safety of the service being delivered.

Capacity and capability

Overall, there were management systems in place to ensure that the service provided was safe, consistent and appropriate to residents' needs. On the day of inspection, there were sufficient numbers of staff to support the residents' assessed needs. However, some improvement was required in the staffing arrangements and training and development.

There was a clear management structure in place. The centre was managed by a full-time, suitably qualified and experienced person in charge. The person in charge reported to a community services manager, who in turn reported to the Director of Services. There was evidence of regular quality assurance audits taking place to ensure the service provided was effectively monitored. These audits included the annual review for 2020 and the provider unannounced six-monthly visits as required by the regulations. The quality assurance audits identified areas for improvement and action plans were developed in response.

At the time of the inspection, the centre was operating with 1.5 whole time equivalent vacancies. The inspector was informed that the provider was in the process of recruiting to fill these vacancies. A review of a sample of staffing rosters demonstrated that there was an established staff team and a regular relief panel in place which ensured continuity of care and support to residents. There were three staff present in this centre during the day and two staff present at night. Throughout the inspection, staff were observed treating and speaking with the resident in a dignified and caring manner.

However, the staffing arrangements in place required review. For example, as identified on the previous inspection, one-to-one personal assistant hours were not fully in place. While, the provider had addressed this by recruiting for a personal assistant, a change in staff meant that the issue remained ongoing at the time of this inspection. It was evident that the provider had put in interim arrangements in place to ensure the provision of eight of the 20 one-to-one personal assistant hours. This had an impact on the care and support that could be provided to the resident

and impacted on the activities of all residents. In addition, the staffing arrangements in place at night time required review. As noted, two staff are present in the centre at night in line with the assessed needs of the residents. At times during the week, one of the staff members had additional responsibilities as the night supervisor to the area and may be required to attend another service. This arrangement required review as it posed a potential risk in meeting the care and support needs of residents at night time. For example, in the case of an emergency such as a fire.

The inspector reviewed a sample of staff training records and found that the staff team had up-to-date training in areas including safe administration of medication and safeguarding. In addition, staff received specific training in areas including epilepsy management, oxygen and feeding, eating and drinking. For the most part, where staff were identified as needing refresher training there was evidence that this had been booked. This meant that, for the most part, the staff team had the skills and knowledge to support the needs of the service users. However, a number of the staff team required refresher training in Percutaneous Endoscopic Gastrostomy (PEG) and deescalation and intervention techniques.

Registration Regulation 5: Application for registration or renewal of registration

The application for the renewal of registration of this centre was received and contained all of the information as required by the regulations.

Judgment: Compliant

Regulation 14: Persons in charge

The registered provider had appointed a person in charge of the designated centre. The person in charge worked in a full-time role and was suitably qualified and experienced. The person in charge also had responsibility for one other designated centres and was supported in their role by delegating duties to staff members in the centre.

Judgment: Compliant

Regulation 15: Staffing

The registered provider ensured that the qualifications and skill-mix of staff was appropriate to the assessed needs of the residents, the statement of purpose and the size and layout of the centre. There was an established staff team in place which ensured continuity of care and support to residents. The person in charge

maintained a planned and actual roster. The inspector reviewed the roster and this was seen to be reflective of the staff on duty on the day of inspection.

However, the staffing arrangements required further review. For example, one-to-one personal assistant hours were not fully in place. While, it was evident that the provider had put in interim arrangements in place to ensure the provision of eight of the 20 one-to-one personal assistant hours, this had an impact on the care and support that could be provided to all residents. In addition, at times during the week, one of the two night time staff members held the role as the night supervisor to the area and may need to attend another service if required. This arrangement required review as it posed a potential risk in meeting the care and support needs of residents at night time. For example, in the case of an emergency such as a fire.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There were systems in place to monitor staff training and development. For the most part, the staff team had up-to-date training. A review of a sample of staff training records demonstrated that the staff team had up-to-date training in areas including safe administration of medication and safeguarding. In addition, staff received specific training in areas including epilepsy management, oxygen and feeding, eating and drinking. This meant that the staff team had the skills and knowledge to support the needs of the service users. However, a number of the staff team required refresher training in de-escalation and intervention techniques and Percutaneous Endoscopic Gastrostomy (PEG) care.

A clear staff supervision systems was in place and the staff team in this centre took part in formal supervision. The person in charge had a supervision schedule in place and the inspector reviewed a sample of the supervision records which demonstrated that the staff team were appropriately supervised.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place. The centre was managed by a full-time, suitably qualified and experienced person in charge. The person in charge was responsible for one other designated centre and was supported in their role by delegating duties to staff members in the centre. There was evidence of regular quality assurance audits taking place to ensure the service provide was safe, effectively monitored and appropriate to residents' needs. The audits included an annual review and six-monthly unannounced audits of the quality

of the care and support provided. The audits identified areas for improvement and action plans were developed in response.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider prepared a statement of purpose which accurately described the service provided by the designated centre and contained all of the information as required by Schedule 1.

Judgment: Compliant

Regulation 31: Notification of incidents

Incidents and accidents occurring in the centre were appropriately notified to the Chief Inspector as required by Regulation 31. The person in charge was aware of the requirements around informing the Chief Inspector in writing of adverse incidents occurring in the centre.

Judgment: Compliant

Quality and safety

Overall, the management systems in place ensured the service was effectively monitored and provided appropriate care and support to the resident. The inspector found that this centre provided person-centred care in a homely environment. However, improvement was required in premises, personal plans and fire safety arrangements.

The inspector reviewed a sample of resident's personal files. Each resident's health, personal and social care needs were assessed through annual health assessment and visioning assessment. The residents had clearly identified person-centred identified roles and goals. There was evidence of regular review and progression in achieving residents goals.

The assessments informed the resident's personal support plans. For the most part, the plans were found to suitably guide the staff team in supporting the residents with their assessed health, personal and social care needs. However, the personal plans required improvement. For example, a number of plans in one residents

personal plan had not been reviewed in the last year. The inspector was informed that this care plan was currently being reviewed. In addition, one advanced directive healthcare plan reviewed in place had not been reviewed within the last year and did not provide clear guidance to the staff team.

There were positive behaviour supports in place to support residents to manage their behaviour. The inspector reviewed a sample of positive behaviour support plan and found that they appropriately guided the staff team. The residents were supported to access allied health professionals as appropriate including psychology and psychiatry. The previous inspection found improvements were required in the identification of restrictive practices. This had been addressed. The restrictive practices in use in the centre had been appropriately identified and reviewed in line with the provider's policy.

There were effective systems in place for safeguarding residents. The inspector reviewed a sample of adverse incidents occurring in the centre which demonstrated that incidents were reviewed and appropriately responded to. There were safeguarding plans in place to manage identified safeguarding concerns. The residents were observed to appear comfortable and content in their home.

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place, including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. There was evidence of regular fire evacuation drills taking place in the centre. The residents had a personal emergency evacuation plan (PEEP) in place which guided the staff team in supporting the residents to evacuate. However, the arrangements in place for the safe evacuation of residents at night time required review.

Regulation 17: Premises

Overall, the designated centre was decorated in a homely manner and well maintained. The designated centre is a detached bungalow located close to an urban area in Co. Kilkenny. All residents had their own bedrooms which were decorated to reflect the individual tastes of the residents with personal items on display.

However, some improvement was required in the accessibility of the centre and suitable storage. For example, the inspector observed a number of supportive equipment being stored in the office, bathroom and bedrooms of the centre. This had been self-identified as an area for improvement by the provider. The centre was wheelchair accessible throughout, apart from the double door leading from a bedroom to the garden. This had been identified on the previous inspection and at the time of the inspection it remained in progress.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There were systems in place for the assessment, management and ongoing review of risks in the designated centre. General risks were managed and reviewed through a centre-specific risk register. The risk register was up-to-date and outlined the controls in place to mitigate the risks. The residents had number of individual risk assessments on file so as to promote their overall safety and well-being, where required. The individual risk assessments were also up to date and reflective of the controls in place to mitigate the risks.

Judgment: Compliant

Regulation 27: Protection against infection

There were systems in place for the prevention and management of risks associated with infection. There was evidence of contingency planning in place for COVID-19 in relation to staffing and the self-isolation of residents. There was infection control guidance and protocols in place in the centre. The premises were observed to be clean and the inspector observed a cleaning schedule in place. There was sufficient access to hand sanitising gels and hand-washing facilities observed through out the centre. All staff had adequate access to a range of personal protective equipment (PPE) as required. The centre had access to support from Public Health.

Judgment: Compliant

Regulation 28: Fire precautions

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place which were serviced as required. There was evidence of regular fire evacuation drills taking place and the residents had a personal emergency evacuation plan (PEEP) in place. However, the arrangements in place for the safe evacuation of residents at night required review as the last simulated night time fire drill took 11 minutes to complete with two staff members. In addition, at times during the week, one of the night time staff members had additional responsibilities which may require them to attend another service.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had a comprehensive assessment of their health, personal and social care needs. The assessments informed the residents personal plans which were found to be person-centred. The inspector reviewed a sample of residents' personal plans and found that care plans were in place in line with residents' assessed needs. However, personal plans required review as a number of support plans had not been reviewed within the last year.

Judgment: Substantially compliant

Regulation 6: Health care

The health-care needs of residents were suitably identified. Healthcare plans outlined supports provided to residents to experience the best possible health. Residents were facilitated to attend appointments with health and social care professionals as required. However, an advanced health care plan reviewed had not been updated to reflect the residents needs and did not suitably guide staff in meeting the residents needs. This care plan had not been reviewed within the last year.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The resident was supported to manage their behaviours and positive behaviour support guidelines were in place which appropriately guided staff in supporting the resident. The resident was facilitated to access appropriate health and social care professionals including psychology and psychiatry as needed.

Restrictive practices were in use in the centre on the day of the inspection. From a review of records, it was evident that it was appropriately identified and reviewed on a regular basis by the registered provider.

Judgment: Compliant

Regulation 8: Protection

The registered provider and person in charge had systems to keep the residents in the centre safe. There was evidence that incidents were appropriately managed and responded to. Formal safeguarding plans were in place for identified safeguarding concerns. Staff were found to be knowledgeable in relation to keeping the resident safe and reporting allegations of abuse. The residents were observed to appear relaxed and content in their home.
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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Substantially 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	Substantially compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Country Lodge OSV-0005827

Inspection ID: MON-0033673

Date of inspection: 12/08/2021

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:
Due to the previous personal assistant (PA) leaving the service, recruitment is underway for PA hours for one person supported in Country Lodge. The PIC is currently providing 8 PA hours per week for the person supported through additional staffing to ensure the supports as per personal plan.
Two staff members from SPC Community Hub are also assigned to the person supported to provide music therapy and individualised supports as part of personal plan.
The PIC will also review the option of the Irish Wheelchair Association to provide PA hours, as done so pre COVID-19 pandemic.

A meeting was held on the 23/08/2021 between the PPIM, Assistant Director of Service, a representative of night manager team and PICs to discuss the development of a contingency plan of night staffing and response arrangements across SPC service. Support needs for people supported and potential risks were discussed. The night manager was assigned the action to draft the contingency plan for staffing arrangements to ensure safe and quality service. The drafted contingency plan was further discussed on the 23/09/2021 and the night manager has now finalised the contingency plan with all amendments discussed.

This SPC night time contingency plan outlines the night staffing complement across SPC designated houses and role of the night manager in managing same. The plan is outlining 4 stages of responses in the event of identified issues and guide the night manager in their risk management and decision making. The SPC night time contingency plan has been sent to the inspector.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Following update regarding training for staff team:-

• Staff members are booked to complete their PEG refresher training on the 08/09/2021.

• The PIC has also arranged for the Behaviour support specialist to provide training in Low arousal techniques for the staff team in Country Lodge on 20/09/2021 and 01/10/2021 to ensure the team has the appropriate skills to support the people living in Country Lodge.

The PIC and staff team are discussing training needs and refresher training in team meetings and also follow up through Quality Conversations.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A business case has been submitted in July 2021 to the HSE on behalf of a person supported in Country Lodge to provide funding for necessary adaptions regarding access from bedroom to the garden to eliminate a restriction. SPC is awaiting feedback on the submitted business case.

The PIC and staff team are exploring the option of purchasing bigger wardrobes for person's bedrooms to provide additional storage space. SPC has also applied for funding to purchase storage sheds for some designated centres and are currently awaiting confirmation of funding payment. Country Lodge will be provided with one of these sheds for further storage space.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
H & S department has requested support from fire training officer/fire fighter to attend a fire drill in Country Lodge and provide guidance on fire evacuation, especially at night time. A date to be confirmed.

All bedrooms in Country Lodge are installed with 30-minute rated fire doors and hold

open devices, which are connected to the fire alarm system. Fire doors are inspected on a weekly basis and local fire station is located within 5 minutes of Country Lodge. Staff team will liaise with local fire station to discuss individual needs of people supported in Country Lodge and provide floor plans.

As outlined under Regulation 15, SPC has developed contingency plan for night time supports and was sent to the inspector on the 30/09/2021.

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 PIC and staff team are further progressing the development of personal plans for all people living in Country Lodge. Keyworkers are supported through On the Job Mentoring from Service Enhancement team to build further capacity within the team around person centred planning. Monthly reviews and weekly plans are being developed further to reflect each person's roles and goals.
Quality Department has also requested a Personal Planning Framework audit to be completed across the service to ensure further implementation of the system.
Regarding a person's support plan the PIC has contacted medication management officer to provide further guidance and finalise the drafted plan to ensure a holistic approach is being followed (see also Regulation 6 – Health Care).

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The PIC has contacted the medication management officer to arrange a meeting for review of the advanced health care plans for a person supported in Country Lodge. This review will ensure that most accurate information is available to the staff team for a safe and good quality support for person living in Country Lodge.

The PIC, a staff nurse who is keyworker for the person supported and the medication officer will finalise the drafted plans, discuss with the GP and sign latest by the 30/09/2021. The PIC will ensure all staff members are aware of same.

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	30/09/2021
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	01/10/2021
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best	Substantially Compliant	Yellow	30/11/2021

	practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/11/2021
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	30/10/2021
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but	Substantially Compliant	Yellow	30/09/2021

	no less frequently than on an annual basis.			
Regulation 06(3)	The person in charge shall ensure that residents receive support at times of illness and at the end of their lives which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.	Not Compliant	Orange	30/09/2021