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:	St. John of God Kildare Service DC 11
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	06 January 2022
Centre ID:	OSV-0004137
Fieldwork ID:	MON-0034072

About the designated centre

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

DC 11 is a residential service operated by St. John of God Services and is located in a large town in Co. Kildare. The designated centre is comprised of two detached houses in a housing estate, next door to each other. Both properties are a two storey building, building one has capacity for three residents and building two has capacity for five residents. Building one has been adapted to meet the accessibility needs of residents. DC 11 supports eight male residents with an intellectual disability by a team of; social care workers, a social care leader and a person in charge. Staffing levels are based on the needs at each location. Some residents have the support of staff sleeping over; while other residents have the support of staff dropping in to their home to provide specific supports like assistance with cooking/sorting out domestic bills/support with safety checks. Residents have access through a referral system for the following multi-disciplinary supports; psychology, psychiatry, social work. All other clinical supports are accessed through community based primary care with a referral from the individuals G.P. as the need arises. There is also an accessible vehicle for residents use in accessing the community along with well serviced public transport.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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 6 January 2022	09:05hrs to 16:40hrs	Erin Clarke	Lead

What residents told us and what inspectors observed

On arrival at the first centre, one of the residents greeted the inspector at the front door and showed the inspector around their home. They had remembered the inspector from a previous inspection and was able to discuss and point out improvements that had been made in their home since then. They showed the inspector their bedroom and the downstairs area of the house. While the resident was content with their living environment they felt that further adaptations would be beneficial to them as they demonstrated to the inspector that some tasks were difficult for them. The resident was aware of their right to provide feedback to the provider and also of their right to make a complaint. While the resident had used the complaints procedure in the previous months they were dissatisfied that the complaint had not been responded to and requested that the inspector to escalate this matter on their behalf.

A second resident returned to the house after being out and greeted the inspector as they went into their bedroom. They used a key to open their bedroom door and locked it again when they left their bedroom which ensured residents' right to privacy was respected when they were not present in their house. The inspector met with two residents in the second house and also was shown around the house. Residents in this house had high levels of independence and did not require the support of staff for many of their activities and were observed laughing with staff and talking about their day. While residents' needs differed in their requirement for staff support, the inspector found residents' preferences and needs indicated a higher level of staffing hours than those currently available.

Residents told the inspector that they were very happy being able to resume visits with their families and friends again. They told the inspector they missed attending work and engaging in activities in the community. This had impacted them a lot and they told the inspector they were happy that their daily routines and activities were back to the way they were before the pandemic restrictions had occurred. It was clear from observing residents coming and going to the centre independently that the ability to freely access public transport, visiting shops and cafes, shopping and other activities was of importance and therefore, was supported and encouraged by staff.

The inspector found that residents were consulted about the care and support they were provided with in the designated centre. On a regular basis, residents met with their keyworker for a consultation meeting to discuss the progress of their goals including other matters such as keeping safe during COVID-19, trying out new activities, goal planning and returning to normal activities but to mention a few.

In addition to meeting residents and staff along with observing their interactions during this inspection, the inspector also reviewed documentation relating to the centre overall and individual residents. Such records reviewed included notes of residents’ meetings that took place in the centre on a monthly basis. Such meetings

were facilitated by staff and were used to give residents information on issues such as home improvements, safeguarding and fire procedures. Residents were also informed of certain news events. For example, residents were informed of the occurrence of scam calls, should they receive any and what steps they should take.

Overall, the inspector observed the house to have a homely atmosphere with lots of photographs throughout the centre of residents enjoying various activities with their friends and family. Overall, the layout of the house met the needs of the residents however, the inspector observed that some decorative and structural repairs were required in the centre. These have are addressed in the quality and safety section of the report.

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

Capacity and capability

The inspector found that the provider had most of the necessary arrangements in place to ensure that residents received a safe service. The service was overseen by a competent person in charge who was aware of the residents' support needs. The inspector discovered that clear lines of responsibility existed at the individual, team, and organisational levels, ensuring that all staff at the centre were aware of their obligations and to who they were accountable to. Improvements in capacity and capability requirements were needed to ensure that the person in charge was adequately supported by the registered provider to ensure sufficient oversight of service delivery. The staffing arrangements also needed to be reviewed in line with residents' assessed needs. However, the inspector was satisfied that the provider had already self-identified these issues and had plans in place to remedy them.

The inspector reviewed the staffing arrangements of both houses in this designated centre. Depending on the assessed needs' of residents, some residents are supported by staff on a 24/7 basis, while other residents are supported by staff who drop in on a regular basis to provide assistance with tasks and safety concerns associated with activities of daily life. According to information examined in the centre, there are two staff on duty three days a week, one on duty four days a week, and one sleepover staff. Due to the limited amount of staff hours available in the centre, it was apparent through speaking with residents, staff and checking rosters that this staffing level could not be consistently applied. The inspector was advised that there had been an increase in resident needs that required additional support. A ninth service user who lived outside of the designated centre also received some support hours from the staff team. The provider had produced a business case for additional hours based on the residents' needs, but these hours had not been approved at the time of the inspection.

There was a suitably qualified and experienced person in charge who met the management experience and qualifications requirements of Regulation 14. They were responsible for four designated centres. The provider had established governance systems to support their regulatory management responsibilities. A centre-based supervisor was part of the centre's management team and assisted with the inspection facilitation. Due to the person in charge's expanding remit and increased responsibilities, their capacity to maintain a regular presence in the centre had been compromised, and this had been recognised by the provider. The inspector observed that due to demands in other areas under the person's in charge remit, plans to restructure the designated centres, which would reduce these commitments were shared with the inspector.

There was a schedule of staff training in place that covered key areas such as safeguarding vulnerable adults, fire safety, infection control and manual handling. The person in charge maintained a register of what training was completed and what was due. However, there were refresher training gaps noted across some training areas.

The inspector found that there were arrangements in place to monitor the quality of care and support in the centre. Various review audits were conducted in the centre by the person in charge and supervisor on key areas related to the quality and safety of care provided to residents. The provider had ensured that an unannounced visit to the centre was carried out in accordance with the regulations. These were found to be of a good quality and reviewed specific regulations in detail, providing a quality action plan for any areas that required improvement.

Regulation 14: Persons in charge

The provider had appointed a capable full-time person in charge of the centre who was also responsible for three other centres. The person in charge was found to be suitably skilled, qualified and experienced to fulfil the role. While a review of the person in charge's current administrative hours was warranted to ensure the effective governance, operational management and administration of the designated centre, the provider had self-identified this issue and planned to reconfigure the person in charges areas of responsibility.

Judgment: Compliant

Regulation 15: Staffing

The inspector found that the staffing arrangements generally in place for this centre was not appropriate to the size and layout of the houses and the collective needs of residents. While staff provided drop-in staff support to one house and were

reachable by phone, one resident reported that the increased number of phone calls was disturbing their sleep. Also, for the same resident who was provided with day service hours from the centre, these hours were not consistently provided due to competing demands made of staff.

There was also limited opportunities to engage in one-to-one activities outside of the centre with the support of staff. The inspector acknowledged that the provider had identified this deficit and had submitted a business case for additional staffing hours however this had not been finalised by the time of the inspection.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff were completing formal one to one supervisions with the team leader. This included a review of staff performance and professional development. There were some gaps in training and although the person in charge had endeavoured to schedule training as required, all gaps had not been addressed at the time of inspection.

One staff required refresher training in fire safety.
Two staff required refresher training in emergency medicine administration.
One required refresher training in diabetes management

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had ensured six-monthly provider-led audits for the centre had been completed for the previous year and were available for review during the course of the inspection. These were noted to be of a good quality and comprehensive in scope with the provision of an action plan for the person in charge to address.

The provider had recognised that the operational management oversight arrangements required review due to the large remit of the person in charge and the inspector was provided with assurances to address this.

Judgment: Compliant

Regulation 34: Complaints procedure

One resident made a complaint in November 2021 regarding the availability and cost of an accessible weighing scales and expressed concern to the inspector regarding the management of this complaint. The inspector found that the provider's complaint procedure had not been followed in terms of receiving the complaint and in relation to the management of the complaint. Furthermore, the complaints procedure was not displayed in the centre to present residents with clear information. A number of complaints regarding premises and staffing issues were also brought to the attention of the inspector and while these were generally known by management, they had not been captured as complaints to ensure effective oversight of feedback from residents.

Judgment: Not compliant

Quality and safety

Speaking with residents and staff, it was clear that every effort was being made to ensure that residents felt happy and protected in their homes. Residents were encouraged to develop and retain their independence, as well as participate in the centre's day-to-day operations.
It was evident that the person in charge and staff were aware of residents' needs and knowledgeable in the person-centred care practices required to meet those needs. However, improvement was required in relation to the premises to ensure it was maintained in a good standard which in turn would enhance the infection control measures in the centre. Furthermore, improvements to the fire containment measures were required to ensure the appropriate levels of safeguards within the centre.

The inspector carried out observations of the premises in both houses. Overall, each residential house was warm, well ventilated and bright throughout. Each resident had their own private bedroom space and bathroom and toilet facilities were adapted to meet their needs.
However, premises improvements were required, across both houses, to ensure they were maintained to a good standard and in a manner that ensured optimum infection control standards.

The inspector reviewed the fire safety precautions throughout the designated centre. Emergency lighting was located at key areas, fire servicing checks were up-to-date and fire evacuation drills were carried out with good frequency. It was also demonstrated the provider had considered the evacuation procedures for residents that did not require staff support at all times. While the provider had installed fire doors throughout both residential houses, not all doors had been fitted with door closing devices. This required improvement to ensure the most optimum fire containment measures were in place, however the inspector was aware of the provider's improvement plan within this area.

Overall, the risk management in the centre was effective, with evidence of staff following the provider's risk management policies and procedures. A risk register was kept and updated as necessary. The register provided an overview of all risks in the centre. The inspector identified that improvements were required to the updating of risk assessments to ensure they reflected the control measures in the centre as detailed in regulation 26 risk management.

There was evidence that the provider followed both national and local policies and procedures for safeguarding vulnerable adults. Staff had undergone up-to-date and refresher training in the area of protecting vulnerable adults. Safeguarding plans were in place where they were needed. During the summer months, there was an increase in the incidence of peer-to-peer safeguarding episodes in one residential house. This was attributed to the fact that some residents' day services, employment and routines had changed. The person in charge and the provider took responsive steps to review these issues, as evidenced by the reduction in these incidents.

The inspector examined a sample of the residents' personal plans. There was an assessment of need that was updated at least annually, and a support plan was in place for each need identified. Personal goal-setting was also in place, with key working staff and residents reviewing it on a regular basis. Personal plans were also adjusted to suit the changing demands of the residents. For example, one resident wanted to change employment. There was evidence to show that residents' changing needs were thoroughly looked at through an allied professional framework with guidance for staff on how to support residents.

Regulation 17: Premises

Overall, the property was well-kept, with the necessary assistance aids, and mobility devices in place for residents. To ensure that all of the centre's facilities were fully accessible, adjustments were needed in certain areas. Some improvements to the premises was required to ensure they were kept in good condition.

- The inspector observed one external door was difficult to close despite repeated repairs to the door.
- The pedal bins in one house could not be operated by wheelchair users, this also applied to some switches as reported by a resident.
- An outdoor light reported as broken since November 2021 had not been replaced.
- There was ceiling damage residue in one house from a water leak.

There were improvements required concerning the premises that were having an impact on the overall infection control measures and standards in the centre and these are addressed under regulation 27 Protection against infection.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had a risk management policy in place. Various risk assessments were completed relating to the designated centre overall and for individual residents. Residents also were supported by the positive risk taking culture within the centre to ensure residents' independance and rights were maintained. While some risk assessments had been recently reviewed, the content contained within them did not reflect the current control levels or circumstances. For example:

- One risk assessment concerning a resident staying at home alone without staff support had not been changed since 2019. The risk assessment stated the resident was capable of all transfers from their wheelchair however, due to a decline in the mobility needs of the resident this risk assessment required review.
- There was a risk assessment in place for poor access and egress into one house. A control measure in place to remedy this was the fixture of external lighting. However, this was not working since November 2021. COVID-19 risk assessments required review as they contained obsolete measures including residents taking showers after visits and washing of clothes at 60 degrees.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had ensured that systems were in place for the prevention and management of risks associated with COVID-19. There was evidence of ongoing reviews of the risks associated with COVID-19 with contingency plans in place for staffing and isolation of residents if required. The provider and person in charge had ensured that all staff were made aware of public health guidance and any changes in the procedure relating to this. Staff and residents were responsible for the day to day cleaning in the centre and in addition cleaning staff were provided as an additional cleaning resource for four hours per month.

The inspector observed some practices in the centre that impacted upon the overall infection control standards in the centre.

- Cleaning products and items in one house were located next to the toilet creating a contamination risk.
- There was rust on some radiators and fixtures in the bathrooms impacting effective cleaning.
- The practice of using sharp boxes for used lancets required reviewed. The inspector observed the temporary closure on the lid was not closed over to prevent contents from spilling when not in use. The sharps box also was not signed and dated by the assembler to ensure it was correctly disposed of in line with best

practice.
- There was a build-up of mould in one bathroom.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were satisfactory systems in place for the prevention and detection of fire. The inspector found that residents took part in planned evacuations and that learning from fire drills was incorporated into personal evacuation plans.

There were some areas in the two houses that did not have sufficient fire containment measures. The provider had recognised the requirement for improving these measures and there was an approved plan to roll out improvement works to all designated centres within the service.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents had individual personal plans in place which were informed by relevant assessments and contained a good level of information on how to support residents with their needs. As part of the personal planning process each resident had a keyworker assigned to them to support them with their goals while a person-centred planning process was also followed. Residents plans had input from relevant health and social care professionals as required and it was noted that residents had good access to health professionals if required.

There was photographic evidence of the activities which residents had enjoyed during the pandemic and the plans were audited regularly to ensure goals continued to progress for residents.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where necessary residents had positive behaviour support plans in place and the centre also had support from the organisations behavioural therapist. Part of the plans also included skills teaching as part of the proactive strategies. These plans were reviewed on a regular basis to ensure the strategies put in place were effective. Recent quarterly notifications indicated that there were no restrictive

practices in use. During the course of this inspection, the inspector did not observe any such practice.

Judgment: Compliant

Regulation 8: Protection

No current safeguarding concerns were identified during this inspection and it was seen that where any concerns did arise the appropriate bodies were notified with safeguarding plans put in place where necessary. Records provided indicated that all staff member had undergone relevant safeguarding training.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were seen to be treated in a respectful manner throughout inspection. The provider was making considerable efforts to ensure that residents could exercise choice and control in their daily lives. Access to advocacy services was encouraged and facilitated where required. Regular house meetings were taken place while residents were also given an opportunity to discuss matters on a one to one basis if required.

Personal care plans and intimate care plans demonstrated that residents were treated with dignity and respect. Residents were provided with lots of choice around activities, meals and the environment they lived in.

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	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for St. John of God Kildare Service DC 11 OSV-0004137

Inspection ID: MON-0034072

Date of inspection: 06/01/2022

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. Staffing requirement to meet assessed needs has being identified and business case for additional staffing will be prepared and forwarded to the HSE CHO7 by 31.03. 2022	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. One staff required refresher training in fire safety. This training will be scheduled and completed by 31.05.22 2. Two staff required refresher training in emergency medicine administration. This training will be completed by 13.04.22 One staff member required refresher training in diabetes management. Completed on 26.02.22	
Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure:	

1. All complaints will be recorded in line with SJOG complaint policy; logged on complaints log in the Designated Centre. Complete as of 07.01.22. 2. Documentation in relation to complaint regarding weighing scales placed on file in complaints log. Complete as of 07.01.22 3. Complaints procedure and photo of Complaints Officer displayed on resident's notice board in communal area. Completed as of 07.01.22.

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: 1. Lock to be replaced on external door as it is difficult to repair despite repeated repairs . Completed by 03.03.22 2. Accessible bin for use by wheelchair user installed as of 28.02.22 3. A review of accessbility of environment and use of technology to be carried out for one resident by social care leader and the PIC by 31.03.22 4. An outdoor light that required repair since November 2021 was repalaced on 08.01.22. Ceiling damage residue in one house from a water leak will be repaired by 30.04.22	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: 1. All Covid Risk Assessements have being reviewed and updated in line with public health advice. Completed on 28.02.22 2. Individual risk assessment updated in line with changing needs. Completed on 28.02.22	
Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection:	

1. All Cleaning products will be stored in identified storage area in each location (kitchen / utility). Completed on 31.01.22
2. Rusting radiators and fixtures identified in the bathrooms will be replaced by 30.04.22.
3. Staff re-induction on Sharps Management Local Operational Procedure and SJOG IPC policy to be completed by 31.03.22
4. Spot check completed by the PIC re compliance with LOP. No issue or non-compliance observed on 16.02.22.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. External Fire Safety Consultant Company completing fire safety audit completed by 28.02.22
Recommendations from this audit will be actioned for completion by 30.06.22

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	31/03/2022
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	31/05/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	30/04/2022

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best 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.	Substantially Compliant	Yellow	31/03/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Yellow	28/02/2022
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated	Substantially Compliant	Yellow	31/03/2022

	infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/06/2022
Regulation 34(1)(d)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre.	Not Compliant	Orange	07/01/2022
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	07/01/2022