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:	Milford
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Limerick
Type of inspection:	Short Notice Announced
Date of inspection:	21 April 2021
Centre ID:	OSV-0007872
Fieldwork ID:	MON-0031388

About the designated centre

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

Milford is a detached bungalow located on the outskirts of a city that can provide full time residential care for four residents of both genders over the age of 18 with intellectual disabilities. Each resident has their own bedroom and other rooms in the centre include bathrooms, a kitchen, a dining room, a living room, a utility room and a staff office. Residents are supported by the person in charge, nurses and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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
Wednesday 21 April 2021	10:30hrs to 16:40hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

From what the inspector was told, what was observed and from documents read, the three residents living in this designated centre at the time of inspection had benefited from a move into the community having previously lived in a campus setting. However, some improvement was needed to ensure that residents' rights were fully protected and promoted.

This inspection occurred during the COVID-19 pandemic with the inspector adhering to all national and local guidelines. Social distancing was maintained when communicating with residents and staff, personal protective equipment (PPE) was used and the inspector’s movement throughout the designated centre was minimised in so far as possible. On arriving at the centre the inspector was greeted by the person in charge who directed the inspector to designated PPE donning area. Upon entering the inspector was based predominately in the staff office and left the centre via a specific exit where PPE was also removed and disposed of.

The three residents who lived in this designated centre at the time of inspection had moved into this centre in September 2020 having lived in house for five people on a campus based setting immediately prior to their move here. While this move was initially intended as a temporary measure, from speaking to staff and reviewing documentation in the centre, it was clear that the move had benefited these residents overall. In particular, living with less people and having more space in the current designated centre when compared to their previous home was very positive. For these reasons, staff and the person in charge were advocating strongly for these residents to remain in the centre on a permanent basis. It was also indicated that some consideration was being given to moving a fourth residents into this centre.

By providing more space, residents were in a better position to be more active within the centre. For example, the inspector was informed by staff of how, since moving to this designated centre, one resident was now helping more in the preparation of food. There was also more opportunities for residents to explore the local community where the designated centre was based. Residents went for regular walks in the nearby area while a bus was available for this centre which facilitated residents to go for drives. During this inspection, residents were seen to go for multiple walks and drives throughout the day with staff support. Other activities in the designated centre included arts, music and basketball. Some residents were noted to have recently attended a St Patrick's Day parade in the campus where they used to lived.

While the inspector was based predominately in the staff office during the inspection, there appeared to be a positive atmosphere in the centre. Staff interacted with residents in a respectful and warm manner throughout. For example, one resident indicated that they wanted some paper which the person in charge gave the resident. This appeared to make the resident happy as they smiled. This resident also smiled when staff pointed out to the inspector some photos of

residents from Easter 2021 that were on display near the centre's front door. The other residents in the designated centre were seen to be calm and relaxed during the inspection.

The presence of photos of residents were intended to create a homely feel and overall it was seen that the premises provided for residents to live in was well maintained, well-furnished and clean with some garden areas available to the front and rear of the centre. Each resident had their own bedroom and facilities such as wardrobes to store their personal belongings. Important information for residents such as how to make complaints and the fire evacuation procedures were on display in the centre as required by the regulations. It was observed though that two medicines presses were present in the kitchen area. Both of these presses had signs on them clearly indicating their use which were visible to any visitor who entered the centre via the front door. The presence of these signs did not support a homely feel.

Visits to the designated centre by residents' family members had been facilitated in line with national guidance and restrictions. Residents were also supported to maintain contact with family members through telephone calls and video calls. As this centre had not been open for 12 months at the time of this inspection, an annual review of the centre as required by the regulations had not yet been carried out by the provider. However, the provider was aware of its obligations in this regard including the need to ensure that such an annual review involved consultation with residents and their families.

Efforts were being made to consult with residents on a regular basis through weekly resident meetings that were taking place in the centre. Notes of these meetings were maintained which indicated that all three residents were in attendance but such notes indicated that private medical information relating to individual residents was being discussed. This was not promoting residents' right to privacy. Matters related to COVID-19 were discussed during such meetings also and it was seen that relevant easy-to-read information was available for residents while work had gone into supporting residents around COVID-19 vaccines. Documentation reviewed indicated that for some residents there was consultation with family and staff around such matters although for one resident it was seen that a COVID-19 vaccine permission form contained contradictory information.

In summary, the inspector found that the move to this designated centre had benefited the three current residents particularly in terms of the additional space offered within the centre. While a suitable premises was provided and residents were better able to access the local community, some improvement was needed in relation to aspects of residents' rights such as protecting their right to privacy.

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

Capacity and capability

While the opening of this designated centre had proved beneficial for residents overall, improvement was needed in the management systems in operation, staff consistency and the maintenance of staff rosters.

This designated centre was first registered in September 2020 and was initially intended to provide a temporary home for a group of residents while first safety works were carried out in another designated centre operated by the same provider where these residents usually lived. These works were due to be completed in March 2021 when the involved residents were planned to leave the current centre and return to their previous home. However, these fire safety works had not progressed at the time of this inspection and so the residents remained in the current centre. The purpose of the this inspection was to assess the supports provided to these residents and compliance with the regulations.

As part of this inspection, the designated centre's statement of purpose was reviewed. This is an important governance document which is required by the regulations to contain specific information. It was seen that the statement of purpose contained most of the required information such as how residents' personal plans were reviewed, the arrangements for residents to attend religious services and how complaints raised were managed. It was noted though that the statement of purpose needed some improvement to ensure that it contained all of the required information. For example, it had not been updated to include all of the information contained in the designated centre's certificate of registration while the organisational structure outlined did not reflect the actual reporting structure followed by all staff.

As part of this reporting structure it was noted that that staff working in the centre during the day reported to the person in charge while staff who worked at night reported to a clinical nurse manager who was on duty at night on a nearby campus operated by the provider. During this inspection it was noted that there was increased inconsistency in the staff working in this centre at night. This was evident from staff rosters reviewed. Under the regulations planned and actual staff rosters worked must be maintained. This is important to demonstrate if appropriate staffing supports are being provided to residents and to indicate the identities of those who have actually worked in a centre. The maintenance of actual rosters for this centre was an area for improvement. For example, while reviewing other documentation, the inspector noted one member of staff who had worked in the centre at night but who was not included in the actual rosters provided.

It was seen though that all staff working in the centre had been provided with training in various areas such as safeguarding, fire safety, de-escalation and intervention, food safety and manual handling. Such training helped ensure that staff were equipped with the necessary skills and knowledge to support residents while they lived in this designated centre. The provider also had systems in place to monitor the supports that were provided to residents. For example, one

unannounced visit had been remotely conducted for this centre by a representative of the provider in December 2020 while audits and quality improvement tools had also been carried out in areas such as medicines and infection prevention and control.

Despite these, the overall findings of this inspection indicated that improvement was required to these monitoring systems to ensure that issues related to key matters, such as risk management and fire safety, were identified and responded to promptly. Such issues had the potential to negatively impact the quality and safety of care and support that residents received. It was also noted that a specific action previously identified during an August 2020 HIQA inspection for these residents in the their previous home, relating to individual residents' health and medical information being discussed during communal residents' meetings, was also found during the current inspection.

Regulation 15: Staffing

Actual staff rosters had not been properly maintained in the designated centre. There was an increased inconsistency of staff working in the centre during nights.

Judgment: Substantially compliant

Regulation 16: Training and staff development

All staff working in the centre had been provided with training in various areas such as de-escalation and intervention, food safety and manual handling.

Judgment: Compliant

Regulation 23: Governance and management

The management systems in place required improvement to ensure that issues in areas such as risk management, fire safety and residents' rights were identified and responded to promptly.

Judgment: Not compliant

Regulation 3: Statement of purpose

A statement of purpose was in place that contained most of the required information. It was noted though that the statement of purpose needed review. For example, it had not been updated to include all of the information contained in the designated centre’s certificate of registration while the organisational structure outlined did not reflect the actual reporting structure followed by all staff.

Judgment: Substantially compliant

Quality and safety

A suitable premises had been provided for residents to live but improvement was required in areas such as residents' rights, risk management and fire safety.

The premises of the designated centre was overall presented in a well maintained and well-furnished manner although it was seen that the location of medicines storage required review. Each resident had their own bedroom while communal areas included a sitting room, a kitchen and a living room. The premises was also provided with fire safety systems including a fire alarm, emergency lighting, firefighting equipment and fire doors. Such doors are important to prevent the spread of fire and smoke and to ensure a safe evacuation route in the event of a fire. However, during the inspection it was seen that two of these doors were not functioning as intended which reduced their effectiveness.

Since residents had moved into this centre, fire drills had been carried out to help ensure that residents and staff knew what to do should an emergency evacuation be required. Personal emergency evacuations plans (PEEPs) were also in place for all residents which are important in setting out any supports that residents may need to help them evacuate. When reviewing these the inspector noted that one PEEP indicated that a resident may refuse to evacuate during a fire drill. However, no guidance was provided in the PEEP on how to support this resident should an emergency evacuation be required and the resident refused to evacuate.

It was also noted that the risks associated with this resident potentially refusing to evacuate the centre, had not been risk assessed. In addition, while individual PEEPs were in place for all residents, it was noted that an overall evacuation plan for the centre that took account of the specific needs of some residents, the assistance some residents required and the staffing arrangements in place at night, was not in place. Only one staff member was on duty at night and the potential risks from such an arrangement related to fire safety had also not been risk assessed. Given the increased inconsistency of staff on duty at night in this centre, it was important that clear guidance on evacuating residents both individually and as a group was in place.

Risk assessments were in place though relating to COVID-19 and it was observed that measures were in operation to protect residents from the effects of the

pandemic. For example, on the day of inspection it was seen that there were adequate stocks of PPE and alcohol gel which staff on duty were seen to be using. There was also regular cleaning of frequently touched surfaces carried out while a specific COVID-19 folder that contained key updates from management of the centre was in place.

Records provided indicated that all staff members who had worked in the centre during 2021 had undergone training in PPE and hand hygiene. While no immediate concerns were identified on the day of inspection relating to infection prevention and control, when reviewing staff rosters the inspector did note two instances where a staff member had worked in three designated centres including this centre in a short space of time. Relevant national guidance in place indicated that the movement of staff across centres should be minimised.

Guidance for staff in supporting residents' needs was available in residents' individual personal plans. As part of the personal planning process followed in this centre, individual goals had been identified for residents to achieve. Example of these included redecorating bedrooms, trips away and living with less residents. While the move to this centre had ensured that progress was made with the latter goals, other goals had been curtailed due to COVID-19 while the goals in place for residents had not been updated to take account of their current home. Residents' personal plans were subject to multidisciplinary review and in a recent review of one resident, it was recommended that their goals should be linked more to community living and the activities that they did when in their current centre.

Regulation 13: General welfare and development

Residents were supported to maintain contact with their families. The location of this designated centre allowed residents more opportunities to be part of the local community.

Judgment: Compliant

Regulation 17: Premises

The premises provided for residents was seen to be well maintained, well-furnished and clean. Communal areas were available for residents such as a kitchen and a living room while each resident had their own bedroom with facilities available including wardrobes to store their personal belongings.

Judgment: Compliant

Regulation 26: Risk management procedures

Not all risks present in this centre had been identified and risk assessed to ensure that appropriate control measures were put in place to prevent the potential for harm to occur.

Judgment: Not compliant

Regulation 27: Protection against infection

Adequate stocks of PPE and alcohol gel were available in this centre. There was regular cleaning of frequently touched surfaces. All staff members who had worked in the centre during 2021 had been undergone training in PPE and hand hygiene.

Judgment: Compliant

Regulation 28: Fire precautions

Two fire doors were observed not to be working as intended on the day of inspection. One resident's PEEP indicated that they may refuse to evacuate during fire drills but it did not contain any guidance on how to support the resident to evacuate in the event of an emergency evacuation. An overall evacuation plan was not in place for this centre which took account of the needs of all residents, the assistance they required and the staffing arrangements particularly at night.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

This regulation was not reviewed in full during this inspection but it was observed that the location of medicines presses required review.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

All residents had personal plans in place which were subject to multidisciplinary review. Goals were identified for residents but these had not been updated to take account of residents' current environment.

Judgment: Substantially compliant

Regulation 8: Protection

No safeguarding concerns were identified during this inspection. All staff had undergone relevant safeguarding training.

Judgment: Compliant

Regulation 9: Residents' rights

Communal residents' meetings were taking place in the designated centre but notes of these meeting indicated that private medical information relating to individual residents were being discussed. Signage in place for medicines presses did not promote a homely environment and were visible by any visitors at the front door. A COVID-19 permission form contained contradictory information.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Milford OSV-0007872

Inspection ID: MON-0031388

Date of inspection: 21/04/2021

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 15: Staffing</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 15: Staffing:
• The PPIM and PIC held a meeting on 28th April with night managers regarding the cross-over of night staff & updating the roster if/when changes occur.
• The plan is for an updated roster to be emailed each morning to the PIC confirming the previous night roster. This is currently being developed. This will be included with the night report that is currently in place.
• The PIC has access to planned rosters at all times.
• For staff that work on a part time basis, there is a plan for a set relief staff to cover these shifts to ensure that residents receive continuity of care and support in as far as possible in the context of HR contracts and COVID protocol.</td></tr>
<tr><td>Regulation 23: Governance and management</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management:
• An urgent Maintenance Requisition Form was completed on the day of inspection to fix the two fire doors that were not closing properly. These doors are now fixed.
• A risk assessment was completed on 21st April in relation to one resident who may decline to evacuate at night, outlining how to support him safely out of his home in the event of a fire. The PEEP has been updated to reflect this.
• A night drill will be arranged by 26th May to confirm the effectiveness of the PEEP.
• The house in this designated centre is fully fire compliance in respect of fire safety to 2A standard. The PIC will liaise with the fire safety consultant to develop an evacuation plan specific to Milford with details regarding the needs of the residents and the assistance they require to evacuate, and the staffing arrangements, particularly at night</td></tr>
</table>

time.
• The PIC has met with the staff team on April 27th re-iterate the importance of upholding privacy for each resident at the weekly meeting. A template was devised on April 23rd with appropriate sub headings for these meetings for staff to follow. A new meeting book has commenced and the previous one has been filed. This finding will also be shared at next PIC meeting
• The Covid-19 consent form was reviewed on 23rd April with the keyworker and resident to clarify information required. The consent form was updated.
• In relation to regulation 5, all keyworkers and the PIC will review PCP goals to tailor them in line with their current living environment in the community.
• The PPIM and PIC held a meeting on 28th April with night managers regarding the cross-over of night staff & updating the roster if/when changes occur.
• The plan is for an updated roster to be emailed each morning to the PIC confirming the previous night roster. This is currently being developed. This will be included with the night report that is currently in place.
SOP will be reviewed as appropriate.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• The PIC has updated the SOP to include all of the information contained in the designated centers certificate of registration, and the reporting structure.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• A risk assessment in relation to one resident who may decline to evacuate at night has been completed on 21st April, outlining how to support him safely out of his home in the event of a fire. The PEEP for this resident has been updated. A fire drill at night will take place by 26th May 2021 to confirm the effectiveness of the PEEP.
• Risk assessments are reviewed by the PIC & Staff 3 monthly in line with policy.
• The PIC visits houses on a weekly basis for planned meetings with staff in relation to all resident's needs, which includes assessing & management of any new risks that may arise.
• The house in this designated centre is fully fire compliance in respect of fire safety to 2A standard. The PIC will liaise with the fire safety consultant to develop an evacuation

plan specific to Milford with details regarding the needs of the residents and the assistance they require to evacuate, and the staffing arrangements, particularly at night time.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• An urgent Maintenance Requisition Form was completed on the day of inspection to fix the two fire doors that were not closing. These doors are now fixed.
• A risk assessment in relation to one resident who may decline to evacuate at night has been completed on 21st April, outlining how to support him safely out of his home in the event of a fire.
• All fire equipment is maintained by the facilities manager and external companies, these certificates are maintained in the fire folder.
• The PIC will liaise with the fire safety consultant and develop an evacuation plan specific to Milford with details regarding the needs of the residents and the assistance they require to evacuate, and the staffing arrangements, particularly at night time.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• On the day of the inspection, the PIC removed the signage on the door which stated 'Drug Press'.
• The PIC showed the inspector the Maintenance Requisition Form that has been previously completed requesting a drug press to be installed in the office for appropriate and suitable storage to ensure that any medicine that is kept in the designated centre is stored securely.

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:	
Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The PIC has met with the staff team on 27th April to re-iterate the importance of upholding privacy for each resident at the weekly meeting. A template has been devised with appropriate sub headings for these meetings for staff to follow. A new meeting book has commenced and the previous one has been filed.
• On the day of the inspection, the PIC removed the signage on the door which stated 'Drug Press'.
• The Covid-19 permission form was reviewed on 23rd April with the keyworker and resident to clarify information required. The consent form has been updated.

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(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	01/06/2021
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	01/06/2021
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate	Not Compliant	Orange	11/06/2021

	to residents' needs, consistent and effectively monitored.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	01/06/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	11/06/2021
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.	Not Compliant	Orange	11/06/2021
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to	Substantially Compliant	Yellow	01/06/2021

	ensure that any medicine that is kept in the designated centre is stored securely.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	22/04/2021
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	30/06/2021
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Substantially Compliant	Yellow	01/06/2021
Regulation 09(3)	The registered provider shall ensure that each resident's privacy	Not Compliant	Orange	27/04/2021

	and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.			