Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Shalom
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Short Notice Announced
Date of inspection:	07 December 2020
Centre ID:	OSV-0004873
Fieldwork ID:	MON-0031020

About the designated centre

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

Shalom is a residential service operated by Brothers of Charity Services Ireland. The centre is located on the outskirts of a town in Co. Clare and transport is provided. A maximum of three adults attend the service on a full-time or shared care basis. The support provided is designed to meet a broad range of needs and a staffing presence is maintained in the house at all times. Residents generally receive individualized staff support between 09:00hrs and 21:00hrs. The service is operated from a bungalow type dwelling with residents having their own bedroom, along with access to a communal bathroom, one en-suite facility, kitchen and dining area, sitting room, patio and a large garden area. The model of care is social and the staff team is comprised of support workers with day to day management responsibilities assigned to the person in charge supported by a social care worker.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 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
Monday 7 December 2020	10:15hrs to 16:15hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This centre is registered to accommodate a maximum of three residents on a full-time or shared care basis. The provider had made some changes to how the centre was operated in the context of COVID-19 and the maximum number of residents in the centre at any one time was two. Residents were also receiving an integrated type service with residential staff co-ordinating a programme of activity and engagement for residents rather than residents attending a day service. These measures helped to reduce crossover of staff and services, reduced contacts and reduced the risk of the accidental introduction and onward transmission of COVID-19. These arrangements appeared to be suited to residents and their representatives. One resident resided in the centre on a full-time basis and was at home when the inspector arrived to the house. A resident arrived in the late afternoon for their three-night shared care arrangement. Both residents presented as happy to be in the centre and with the staff on duty and there was no reported or documented dissatisfaction from representatives. In the context of their assessed needs residents did not provide direct verbal feedback to the inspector as to what life was like for them in the centre, but what was evident was broad smiles, comfort and ease with the staff on duty. This warmth was extended to the inspector on arrival and the resident also gave a thumbs up which was a general indicator that all was good. The resident was clearly looking forward to spending time out of the centre and had their coat ready to go. The resident left shortly after the inspectors arrival, and spent most of the day out in the community with staff. In the evening the inspector met briefly with the second resident who availed of a shared care arrangement (shared between home and the centre). The resident was eager to establish who the inspector was and once this was explained there was discussion of favoured animated characters, books and admiration of the new jewellery that the resident had acquired. Clearly there was no unwillingness or unhappiness on behalf of the resident to be spending sometime in the centre. The staffing levels observed were as described and the staff on duty were as listed on the staff rota. The support and general operational arrangements described to the inspector were as observed and as seen in the records reviewed, for example the personal plan and the log of identified risks. Collectively the evidence was a service that was tailored to meet the individual needs and requirements of residents.

Capacity and capability

While there was some scope for improvement, the overall inspection findings reflected a well-managed and effectively overseen service that was operated to meet the individualised needs and requirements of the residents. Based on these inspection findings the service was adequately resourced to meet its stated aims and

objectives.

The management structure was clear and there was clarity on individual roles, responsibilities and reporting relationships. While relatively new to the role the person in charge was aware of their role and responsibilities in the context of the overall governance structure. The oversight that the person in charge maintained of the quality and safety of the service was evident on discussion and in records seen, for example the oversight of risk and of resident well-being in the context of COVID-19 restrictions. The provider ensured that the person in charge had appropriate and adequate mentorship from an experienced manager in preparation for the role of person in charge.

In addition to the day to day oversight maintained by the person in charge the provider was also completing the annual review and the six-monthly unannounced reviews of the quality and safety of the service as required by the regulations. The inspector saw that in completing the annual review feedback was sought from residents and their representatives. Based on the records seen all relevant representatives had provided feedback and there was a high level of reported satisfaction with the care and support provided. Plans for improvement did issue from these reviews but there were no findings of concern based on the reports seen by the inspector. The provider was largely self-identifying deficits and the person in charge maintained oversight of the progress of the improvement plans. For example, based on the findings of this Health Information and Quality Authority (HIQA) inspection, deficits in the verification of staff training found at the time of the most recent internal review (June 2020) were addressed and a plan for the provision of additional fire resistant doors was progressing.

The inspector reviewed a sample of planned and actual staff rotas and saw that each staff and the hours that they worked in the centre was clearly documented. The same staff were listed indicating that consistency was provided for and the number of staff on duty each day varied to reflect the occupancy of the centre. Staffing levels increased with increased occupancy and 1-to-1 staffing was generally provided for from 09:00hrs to 21:00hrs. These staffing arrangements supported the delivery of an individualised service for residents. The night-time arrangement was a sleepover staff and there was no evidence that suggested that this was not appropriate to the assessed needs of the residents. For example, monitors and alarms were used to alert staff to seizure activity, but the assessed likelihood of this happening was low.

The inspector reviewed the record of training completed by staff and saw that deficits identified by the last internal provider review were addressed. For example all staff including recently recruited staff had completed mandatory, desired and required training including safeguarding, fire safety and medicines management. Some baseline and refresher training had to be completed on line by staff using accredited resources given the restriction on practical, face-to-face training as a result of COVID-19; this was risk assessed for any possible associated deficit in learning and skills. The staff training programme was responsive to new risks such as COVID-19 and all staff had completed training that included hand-hygiene, breaking the chain of infection and the correct use of personal protective

equipment (PPE).

The inspector was advised that there was no open complaint. The inspector reviewed the management of the last recorded complaint received in late 2019 and saw that the complaint, the actions taken to investigate the complaint, the communication of the findings to the complainant, their satisfaction and monitoring to follow-up and ensure good practice had continued was all clearly evidenced. However, the complaints procedure including the accessible procedure on display required updating.

Regulation 14: Persons in charge

The person in charge worked full-time and had the qualifications, skills and experience required to perform the role. It was evident from these inspection findings that the person in charge was consistently involved in the management and oversight of the service.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels and arrangements were informed by the number and assessed needs of the residents. Residents received continuity of support and the staff rota was well maintained.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to a programme of training that reflected their role, responsibilities and the assessed needs of the residents. On-line training and blended learning ensured that training and learning continued during the COVID-19 pandemic.

Judgment: Compliant

Regulation 21: Records

The records requested and used by the inspector to inform and validate the inspection findings such as fire safety records, records of restrictions, referrals and appointments, and the food and meals provided were all in place and well maintained.

Judgment: Compliant

Regulation 23: Governance and management

These inspection findings reflected a well managed service where the quality and safety of the service provided to residents was consistently and effectively monitored.The service was adequately resourced to deliver on its stated objectives. The provider was effectively identifying areas that needed to improve and improvement actions that arose from internal reviews were progressed.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose was available in the centre and had been updated to reflect changes that had occurred. These included changes to the management structure and operational changes as to how the service was delivered as a result of COVID-19.

Judgment: Compliant

Regulation 34: Complaints procedure

There was evidence of good complaint management, but the policy and procedure was in need of updating.

Judgment: Substantially compliant

Quality and safety

These inspection findings reflected a service that was planned and operated to

respond to the needs of individual residents. Risk was managed and monitored so that the service was safe and quality improvement plans sought to improve both quality and safety. Residents and their representatives were consulted with and worked with staff so that residents received a continuum of support particularly where support was shared between home and the centre.

The personal plan informed the support and care that was provided to each resident. The inspector reviewed one personal plan and saw that it was individualised to the resident and was based on an assessment of the residents needs, choices and preferences. The plan had been updated to reflect the impact of COVID-19 restrictions on the resident, their daily routine and their planned goals and objectives, for example volunteering in their local community and a hoped for religious pilgrimage. Much of what residents would normally enjoy was restricted such as horse-riding, swimming and socialising. Staff recorded what it was that they did to mitigate the impact of these restrictions such as facilitating safe visits to family and continued access to the local community. It was evident from the plan that the staff team monitored the effectiveness of the plan and consulted members of the multi-disciplinary team (MDT) as appropriate. What was not adequately evidenced however, was how the review of the appropriateness and effectiveness of the plan maximised the participation of the resident, their representatives as appropriate, and the MDT. This was of relevance given the view expressed in the plan that better outcomes could be achieved with and for the resident with different living arrangements. It was not evident how this was concluded, or how the current arrangements were limiting outcomes; MDT discussion was required to explore and to objectively substantiate or not this viewpoint.

The personal plan included the assessment of any healthcare needs and outlined the care that was needed to ensure that residents enjoyed good health. Staff maintained a record of clinical reviews and recommendations and residents had access to services that reflected their assessed needs including their General Practitioner (GP), psychiatry, behaviour support, dental care and chiropody. The care provided was preventative, for example seasonal influenza vaccination had been administered, staff maintained a record of dietary intake and monitored body weight where maintaining good nutrition was a concern. Where residents attended the centre on a less than full-time basis, the person in charge described ongoing communication with families and a collaborative approach to facilitating healthcare.

While the inspector did not review the supply and storage of prescribed medicines there was evidence of practice that reflected regulatory requirements and safe medicines management practice. For example resident capacity and desire to manage their own medicines was formally assessed. The prescription was current, legible and signed by the prescriber; the record of the administration of medicines by staff reflected the instructions of the prescription. Where medicines were prescribed on as needed rather than regular basis, the maximum daily dose was specified and a protocol set out for staff the rationale for their administration. Again, the record of their administration, reflected the instructions of the prescription and the protocol. A daily count of the medicines in stock helped to monitor the administration of medicines as prescribed.

From records seen it was evident that protecting residents from harm and abuse was considered when reviewing the service, care and support provided. Staff had completed safeguarding training, the designated safeguarding officer was available and was contacted as needed.There were risk assessments, plans and systems that safeguarded residents from harm and injury, for example the plans that set out for staff how personal and intimate care was to be provided so that resident privacy and dignity was protected. Body maps were completed to monitor any unexplained injuries and the person in charge described how she maintained regular oversight of these so that their use was meaningful and purposeful.

There were times when residents displayed behaviour that was a risk primarily to themselves. The positive behaviour plan was current and was formulated and reviewed with input from the behaviour support team. The plan set out for staff the purpose of the behaviour, possible triggers, preventative and responsive strategies. The reported frequency and intensity of such incidents was low and the person in charge described how changes to routines in response to COVID-19 had resulted in fewer behaviour incidents. For example changes to the staff rota to reduce footfall as an infection prevention and control measure had resulted in less changes of staff each day and therefore less transitions for the resident to cope with. It was discussed on inspection how this learning would be used to inform the review of the plan going forward.

In reality residents had few restrictions on their lives and routines, those that were in use were based on an assessment of risk and their ongoing requirement and proportionality, was monitored in the context of the residual risk and residents rights. Having reviewed these risk assessments, records of the discussion of purpose and use, and having discussed these with the person in charge, the inspector was satisfied that there was a rationale for their use and they promoted resident safety without unduly impacting on their right to privacy. For example the use of an audio monitor at night if the resident needed to alert staff where the resident did not have the ability to use for example, a call bell.

Overall there was evidence of solid risk identification, management and ongoing review that objectively justified such interventions and ensured that the service, support and care provided to residents was safe, balanced and proportionate. The person in charge maintained a comprehensive log of resident specific, work related and COVID-19 risk assessments. For example a resident requested the use of bedrails as an enabler of upper body strength. Their use was risk assessed and the risk assessment reflected national guidance such as assessing the risk of leaving the bed with the rails in place and ergonomic considerations such as any gaps that posed a risk of entrapment. The impact of COVID-19 restrictions on resident well-being was assessed and balanced with the risk of infection. Controls were implemented so that residents could continue to have safe access to their community and to family, access that was important to their emotional and psychological well-being. The person in charge spoke of how discussion and planning for safe home visits at Christmas had started where this was in line with resident and family wishes.

In general the infection prevention and control practice described and observed

reflected national guidance and the findings of the risk assessments referenced above. Staff had completed the required training, had access to PPE and used it in line with national guidance and the assessed level of risk. The staff rota was managed to reduce footfall and the crossover of staff, staff and resident well-being was monitored at intervals each day. Where residents transitioned on a regular basis between home and the centre, symptoms, well-being and any possible exposure to COVID-19 was established at each transition so as to protect peers and staff. Attendance was staggered, this reduced occupancy and possible contacts and maximised the space available to residents and staff. There were contingency plans for responding to any suspected or confirmed COVID-19. Staff supported residents to develop their hand-hygiene skills and their tolerance of face coverings.

Some improvement was needed to the providers fire safety systems to maximise their effectiveness. The premises was fitted with emergency lighting and a fire detection and alarm system. Certificates seen indicated that these and the equipment for fighting fire were inspected and tested at the required intervals. Fire resistant doors were provided but not throughout the premises and additional doors were needed. Where these doors had been fitted some but not all were fitted with self-closing devices. The absence of fire resistant doors, for example between the kitchen and the living room was risk assessed and there was a plan to provide these doors; this plan should be prioritised and progressed in a timely manner. Staff and residents participated in regular simulated evacuation drills and there was no reported obstacle to the safe and effective evacuation of residents. One bedroom designed to accommodate residents with higher physical needs facilitated bed evacuation to the outside. Different staff participated in the drills including recently recruited staff and good evacuation times were recorded as achieved. However, while the person in charge assured the inspector that simulated drills satisfactorily tested the evacuation procedure, including the bed evacuation provided for in the PEEP (Personal Emergency Evacuation Plan) and the ability of one staff to evacuate both residents, the records of the drills lacked the detail necessary to provide such assurance.

Regulation 10: Communication

Any particular communication support that was needed by a resident was set out in the personal plan and referenced in other records seen such as the records of more formalised meetings held between residents and staff. Such support included describing how residents expressed their voice through gesture, objects of reference or selected words and phrases. For example the person in charge described how a resident would pick up a cup or open a press to communicate to staff their desire for a drink or a snack or how they would tell staff that they were feeling un-well. The consistency of the staff team assisted effective communication given their familiarity with these personal communication methods. Staff were exploring other communication tools such as the use of visuals and a visual planner.

Judgment: Compliant

Regulation 17: Premises

Overall the premises presented well. Residents had their own allocated bedroom, one bedroom was designed and laid out to meet higher physical needs. The premises had its own spacious grounds that residents accessed and used and its location facilitated access to home, a range of services and amenities. However, a need had been identified for access to an additional living-recreational space for a resident and this had been created; staff confirmed that the resident used the room on a daily basis. This room did not present well. The room was a thoroughfare for staff to access administration areas but the primary issue was the utility area that was accommodated off this room in an open-plan design and layout. Openly visible from this room were laundry facilities, a utility sink, fridges and environmental hygiene equipment.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The ongoing identification, management and review of risk supported the provision of a safe service to residents. Risk management processes were responsive to change such as the risk of COVID-19 and the associated risk to residents lives from the necessary restrictions. Based on the evidence available to the inspector any controls that were needed to keep residents safe were reasonable and proportionate and did not unduly impact on residents choices and quality of life.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had policies, procedures, risk assessments and practice informed by national guidance to protect residents and staff from the accidental introduction of and onward transmission of COVID-19.

Judgment: Compliant

Regulation 28: Fire precautions

Fire resistant doors were provided but not throughout the premises and additional doors were needed. Where these doors had been fitted some but not all were fitted with self-closing devices. The absence of fire resistant doors, for example between the kitchen and the living room was risk assessed and there was a plan to provide these doors; this plan should be prioritised and progressed in a timely manner.

While the person in charge assured the inspector that simulated drills satisfactorily tested the evacuation procedure, for example the ability of one staff to evacuate both residents, the records of the drills lacked the detail necessary to provide this assurance.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

While the inspector did not review the supply and storage of prescribed medicines, there was evidence of practice that reflected compliance with regulatory requirements and safe medicines management practice.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

It was evident from the personal plan that the staff team monitored the effectiveness of the plan and consulted members of the multi-disciplinary team (MDT) as appropriate. What was not adequately evidenced however, was how the review of the appropriateness and effectiveness of the plan maximised the participation of the resident, their representatives as appropriate, and the MDT. This was of relevance given the view expressed in the plan that better outcomes could be achieved with and for the resident with different living arrangements. It was not evident how this was concluded or, how the current arrangements limited outcomes; MDT discussion was required to explore and to objectively substantiate or not this viewpoint.

Judgment: Substantially compliant

Regulation 6: Health care

Staff monitored resident health and well-being, ensured that residents had access to

the healthcare services that they required, and provided the care that residents needed so that they continued to enjoy good health.

Judgment: Compliant

Regulation 7: Positive behavioural support

The positive behaviour plan was current and was formulated and reviewed with input from the behaviour support team. The plan set out for staff the purpose of the behaviour, possible triggers, preventative and responsive strategies. Staff had completed training in responding to behaviour of concern or risk including de-escalation techniques.

Interventions that had a restrictive dimension were identified and their purpose, impact and ongoing requirement was the subject of MDT review.

Judgment: Compliant

Regulation 8: Protection

The provider had policies, procedures, risk assessments and plans deigned to protect residents from harm and abuse. There was no reported or identified incompatibility between residents and the provision of individualised support minimised the risk of this. All staff had completed safeguarding training including recent on-line training. The designated safeguarding officer was available as needed for advice and guidance and to ensure that reporting responsibilities were adhered to.

Judgment: Compliant

Regulation 9: Residents' rights

The overall evidence was of a service that was operated with due regard for the individuality of residents, their age, gender, needs, family status and religious beliefs. Narrative records created by staff on a daily basis indicated that residents had choice and made decisions about their routines in the centre and these decisions were respected, for example to participate in a particular activity of not. Staff consulted with residents on an informal and formal basis and staff recorded how residents provided feedback through gesture where expressive ability was limited. The person in charge described regular and ongoing communication

with residents representatives in relation to the support and care provided.
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	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Shalom OSV-0004873

Inspection ID: MON-0031020

Date of inspection: 07/12/2020

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 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The most recent version of the complaints policy is displayed in the DC.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Minor renovations required to enhance a private leisure space and layout of utility area will be a close design plan. • Tender process in line with organization procurement policy to cost and secure contractor will be initiated in January 2021	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Tender process commenced and contractor confirmed to carry out scope of works to install fire doors and self -closing devices. Record of drills will clearly outline the necessary evacuation detail.	

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 Positive Behavior Support Plan will be reviewed by specialist and Leadmore team. • A multi –d meeting is scheduled for 15/01/2021 to discuss and review the Individual Plan and this will be informed by the Positive Behavior support plan	

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 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	31/05/2021
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	28/02/2021
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	Substantially Compliant	Yellow	22/12/2020

	copy of the complaints procedure in a prominent position in the designated centre.			
Regulation 05(6)(a)	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 be multidisciplinary.	Substantially Compliant	Yellow	29/01/2021
Regulation 05(7)(b)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the rationale for any such proposed changes.	Substantially Compliant	Yellow	29/01/2021