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:	Newmarket Residential
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Short Notice Announced
Date of inspection:	23 June 2020
Centre ID:	OSV-0005528
Fieldwork ID:	MON-0029751

About the designated centre

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

This designated centre was originally established in 2017 and registered as a single building which could accommodate two residents.The provider subsequently applied to increase the number of buildings in the designated centre to two so that four residents can reside in the centre. The premises therefore consists of two separate but adjoined ground floor apartments with accommodation provided in each for two residents. Currently one apartment is open on a fulltime basis while the other apartment is funded to open three nights per week.

The centre is located in the heart of the local community and the provider aims to provide, in consultation with residents and their families, a safe and welcoming home environment for residents in their own community. The support provided is tailored to specifically meet each person's needs and to provide opportunities to enjoy independence and participate in social activities, hobbies and community engagement that is suitable, meaningful and age appropriate in everyday settings. Residents receive an integrated type service where both residential and day services are provided from their home. Support is provided by a team of social care staff with management and oversight provided for by a social care worker and the person in charge. Each apartment is staffed by day when residents are at home; at night one staff on sleepover duty provides support as needed for both apartments.

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
Tuesday 23 June 2020	09:45hrs to 15:45hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was undertaken in the context of the ongoing requirement to reduce the risk of the introduction and onward transmission of Covid 19. As the designated centre is comprised of two separate apartments the inspector was based in one apartment, the apartment best suited to facilitating physical distancing and the inspector did not enter the second apartment. Records reviewed however to inform the inspection findings were relevant to both apartments and all residents. The inspector met with one of the three residents living in the centre on the day of inspection.

The inspector received a warm welcome to the apartment. Infection prevention and control measures were in place such as ascertaining inspector well-being and checking of body temperature and these were adhered to in a confident and unobtrusive manner by staff and in a way that did not impact on the normal routine of the apartment or the resident. The atmosphere was relaxed and easy, as was the observed interaction between staff and resident. The resident was seen to enjoy good independence and autonomy in their home as they set about preparing breakfast and enquiring of those present if they would like refreshments. The conversation largely referred to daily routines and activities enjoyed as the inspector was invited to view the residents personal collection of television programmes from the 1980s. There was much laughter as to what it was that made these programmes interesting to watch. There was great excitement that premier football had recommenced and that the favoured team had had a successful first game. Later, having reviewed the personal plan the routine observed was as set out in that plan. Later in the day staff and residents went to collect the grocery shopping and were utilising the click and collect option again as an infection prevention and control measure. The resident reported that this was a great facility and they did not miss going to the shop or queuing for the shopping.

Capacity and capability

Overall the inspection findings established that the provider aimed to provide each resident with a person centred service that was individualised to their particular needs, abilities and wishes. There was evidence of good and effective governance, for example the providers timely and systematic response to the Covid 19 pandemic. However, deficits were identified in systems that underpinned the safety and quality of the service provided, namely in risk management and fire safety systems. These deficits led to a lack of evidence as to how the appropriateness and safety of decisions and arrangements in the centre was assured and assurance that these decisions were made at the appropriate level of the governance structure. Internal systems of review had not identified the deficits identified by this Health Information

and Quality Authority (HIQA) inspection and therefore did not bring about change and drive continuous improvement.

There was a governance structure responsible for the planning, delivery and oversight of the centre. Currently the management team consisted of roles for a social care worker, a co-ordinator and a person in charge; the person in charge reported to the regional manager. The person in charge is person in charge for four designated centres though one of these is currently not operational. The person in charge was aware of the scope of her remit and responsibilities and advised the inspector that there had been discussion at provider level and a plan to reduce the number of centres that she had responsibility for. In the context of these inspection findings and the allocated management resources discussion was also needed as to the delegation of individual roles and responsibilities.

There were internal systems that the provider used to monitor the appropriateness, safety and quality of the service and support provided to residents. These systems of review included seeking feedback from residents and their representatives, review of the personal plans, audits including audits of medicines management practice and the provider reviews required by the regulations to be completed on an annual and six monthly basis. The reports of these latter reviews indicated that the reviews were completed on schedule and they were completed in a detailed manner. Progress on the action plans that issued reported completion of the required improvement actions. However, these HIQA inspection findings would indicate that systems of review did not always identify what it was that needed to improve, or the actions taken were not sufficient, or the improvement was not consistently maintained. For example some records seen while indicating that they had been reviewed had not picked up on issues such as the continued citing of staff not now working in the centre or the fact that the diagrammatic plan of fire zones was still not in place having been requested further to the 2018 HIQA inspection. The evidence to support this finding will be discussed in more detail in the next section of this report specifically in relation to fire safety and risk management processes.

While there was a lack of robustness in the risk assessments that underpinned staffing levels and arrangements, on balance the inspector concluded and the person in charge advised that they were satisfied that the staffing levels and arrangements were suited to the assessed needs of the residents. Both apartments were staffed at all times by day when residents were present and there was evidence that the provider was responsive and proactive in times of change; for example additional staff resources were allocated in response to the Covid 19 pandemic to minimise close resident contact and group interactions. Records including the staff rota and staff training records indicated that a regular team of staff were in post and this ensured familiarity and consistency of care and support for residents. However from 23:00hrs three nights per week, the staffing arrangement for both apartments was one staff on sleepover duty and this was the aspect of staffing and governance that was not robustly assured by the quality of the risk assessments in place. The assurance for the inspector was informed by discussion with the person in charge as to the needs of the residents in the unstaffed apartment and the reported absence of incidents where staff support was

required in this apartment.

There was good oversight of staff attendance at baseline and refresher mandatory, required and desired training such as safeguarding, medicines management and the management of seizure activity. Based on the representative sample of records reviewed by the inspector there were no gaps in staff attendance at training including safeguarding, fire safety, responding to behaviour that challenged and medicines management. In response to the Covid 19 Pandemic all staff had completed training on hand hygiene, infection prevention and control and the correct use of personal protective equipment (PPE).

Records seen such as the internal provider reviews referred to above indicated that there was low number of complaints received and the feedback received from families was positive. There was one complaint on file made by a resident in October 2019 in relation to an aspect of their environment that impacted on the quality of their service. It was not clear from the complaint record how the proposed solution was concluded as the most appropriate solution or if the matter was resolved to the residents satisfaction. The person in charge confirmed that action in response to the residents complaint had not been progressed; systems of review had not identified this.

Regulation 14: Persons in charge

The person in charge worked full-time and met the requirements of the regulation in terms of experience, working hours and qualifications. The person in charge was aware of the responsibilities of their role and confirmed that there was a plan to reduce the scope of their current areas of responsibility. The person in charge described open and supportive working arrangements with senior management that facilitated such open discussion.

Judgment: Compliant

Regulation 15: Staffing

There was a lack of explicit assurance as to how the provider satisfied itself that staffing levels and arrangements were suited to the number and assessed needs of the residents. On balance based on the evidence available as to the assessed needs of residents and the reported absence of incidents such as falls or requests for staff assistance at night the inspector concluded on the balance of probability that staffing arrangements were adequate. Explicit assurance in the form of more thorough assessment of risk and the appropriate simulated evacuation drills was however needed.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were provided with education and training that supported them in the provision of effective evidence based support and care for residents.

Judgment: Compliant

Regulation 23: Governance and management

Deficits were identified in systems that underpinned the safety and quality of the service provided, namely in risk management, fire safety and in the effectiveness of review. These deficits led to a lack of evidence as to how the appropriateness and safety of decisions and arrangements in the centre was assured. Internal systems of review had not identified the deficits identified by this Health Information and Quality Authority (HIQA) inspection and therefore did not bring about change and drive continuous improvement.

Judgment: Substantially compliant

Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent

The provider had notified HIQA of changes to the governance structure and had submitted the required records in this regard.

Judgment: Compliant

Regulation 34: Complaints procedure

It was not clear from the complaint record how the proposed solution to a complaint was concluded as the most appropriate solution or if the matter was resolved to the residents satisfaction. It was confirmed that action in response to the residents complaint had not been progressed; systems of review had not identified this.

Judgment: Substantially compliant

Quality and safety

Overall the inspector found evidence of support and services individualised to the needs, abilities and wishes of residents. The location of the centre and the support provided offered residents opportunity to maintain contact with friends, family and home and to engage meaningfully with their local community. However, while there was assurance provided by discussion, improvement was necessary in systems core to underpinning the appropriateness and safety of the service; that is risk identification and management and fire safety.

The inspector had the opportunity to review one personal plan. The plan was detailed and presented in an individualised and respectful manner and reflected staff knowledge of residents, their assessed needs and individual preferences and choices. The plan was available in an accessible format and the resident had also signed parts of the plan indicating their participation in the support that they received. The plan and the support provided was in addition to staff knowledge informed by advice from other clinicians such as dietetic and neurology services. Staff used monitoring tools to measure the implementation of recommendations such as diet plans and instructed changes were seen to be followed through on, for example a prescribed rescue medication was discontinued following recent clinical review. The plan had been updated to reflect the impact of Covid 19 restrictions on the residents normal routines and quality of life, for example restricted access to home and peers and reduced opportunity for exercise. This provided assurance that the plan guided the delivery of effective care and support and so promoted resident well-being.

Staff monitored resident well-being and ensured that residents had access to the services that they needed in response to their assessed and changing needs such as their General Practitioner (GP), psychiatry, neurology, behaviour support, dental and eye care, podiatry and chiropody. Records were maintained of these reviews and clinical recommendations were integrated into the plan of support and daily practice.

The person in charge confirmed that there were no concerns for the safety of residents; staff had completed safeguarding training and there was good access to and support as necessary from the designated safeguarding officer. The person in charge described how residents were supported to develop their own awareness of and the skills needed for their safety and protection. Residents were described as compatible and records seen supported that residents needs and interests were similar and they therefore lived compatibility together.

There were times when residents were challenged by events and circumstances and communicated this challenge through behaviour that was not safe and was of risk primarily to themselves. Staff ensured that residents had access to the clinical support that they needed such as the behaviour support team; the behaviour, what triggered it and therefore should be avoided and how to respond was clearly set out

in a behaviour specific plan of support.

On a day to day to day basis residents enjoyed minimal restrictions in their home and daily routines; there were two identified interventions with a restrictive dimension, an alarm to alert staff to seizure activity and an alarm to alert staff if a resident left the apartment during times when a staff presence was not maintained. Records seen indicated that the use of these interventions was kept under review. However, the process of review did not demonstrate what the restrictive impact was and how this was considered when it was decided to continue with the intervention. For example did interventions intrude on resident privacy or make residents reluctant to seek staff assistance and how the provider assured itself through review that the benefits outweighed possible impacts and continued use was necessary so as to promote resident safety.

The requirement to provide residents with a service that was safe was clearly understood but not adequately demonstrated in some of the assessments of risks seen by the inspector. The controls referenced in some assessments did not provide assurance that they were sufficient to manage and reduce the risks identified. It was only on speaking with the person in charge that it was evident that there were additional controls in place. It was not evident from the risk assessment that high risk activities were escalated, advised and directed by senior management. For example a decision had been made that it was necessary for residents who had returned home at the onset of the pandemic to return to the centre but also to return home each week; the potential risk that this presented to infection prevention and control was clearly identified and stated. However it was not evident from the associated risk assessment that this was a decision made by senior management in consultation with the funding body; the inspector confirmed with the provider that it was. The controls needed to ensure the safety of all parties while verbally described were not adequately addressed in the risk assessment nor was the action to be taken if concerns arose for resident well-being. Other than verbal handover between staff this risk assessment was the only record available to guide staff during each transfer between home and the centre. In addition and as referred to in the first section of this report the risk assessment to support the safety of the night-time staffing arrangement was not robust. The assessment was generic rather than individualised to the skills and abilities of each resident and did not for example explore each residents understanding of risk, their ability to recognise risk and skills such as their ability to use a phone or household appliances safety. The assessment focused somewhat on the provision of a door alarm to alert staff and so enhance the safety of the arrangement rather than the assessment of each resident and the needs and abilities that made this a safe and appropriate staffing arrangement for them. In addition there were possible risks that had not been identified and risk assessed. For example there was no assessment of the risk of the reverse situation, that is the safety of leaving the other two residents whose reported needs were higher without a staff presence should staff have to go to the other apartment.

Linked to the gaps identified in risk management processes were deficits in fire safety procedures. The inspector was advised that the two residents in the unstaffed apartment had both received fire training, had both successfully participated in simulated drills and would independently respond to the fire alarm. However this

was not clear from the centres evacuation plan or the personal emergency evacuation plans. In addition the provider had not tested the ability of one staff to safely evacuate both apartments and all four residents. The frequency of simulated drills was inconsistent. Records of completed drills indicated that three had been completed in January 2019, one in October 2019 and none since. While all of these drills had been successful none reflected the changes in occupancy or tested the adequacy of the night time evacuation plan. There were two copies of the centres fire plan on file both indicated as reviewed in 2020, however details such as details of responsible persons and persons to be contacted in an emergency were incorrect on one and not picked up on on review. Emergency lighting and self-closing devices had been installed by the provider since the last HIQA inspection. Modifications had been made to these devices so that they fulfilled their function while also facilitating ease of movement for residents. Certificates attesting to the inspection and servicing of the emergency lighting, fire detection and alarm system and fire fighting equipment at the prescribed intervals were all in place. However, diagrammatic or narrative instructions to guide staff so that they could quickly identify zones and the location of a possible fire in either apartment was still not in place having been requested at the time of the previous HIQA inspection.

Regulation 11: Visits

Visits had been restricted in line with national guidelines in response to the Covid 19 pandemic. Staff were aware of the impact of these restrictions on residents and had sought to alleviate the impact by implementing safe solutions such as "drive-by" visits to peers. The revised and relaxed but still controlled guidance on facilitating visits to the centre was available in the centre and its implementation had been discussed with residents.

Judgment: Compliant

Regulation 26: Risk management procedures

The controls referenced in some assessments did not provide assurance that they were sufficient to manage and reduce the risks identified. It was only on speaking with the person in charge that it was evident that there were additional controls in place. It was not evident from the risk assessment that high risk activities were escalated, advised and directed by senior management. As referred to in the first section of this report the risk assessment to support the safety of the night-time staffing arrangement was not robust. The assessment was generic rather than individualised to the skills and abilities of each resident and did not for example explore each residents understanding of risk, their ability to recognise risk and skills

such as their ability to use a phone or household appliances safety. The assessment focused somewhat on the provision of a door alarm to alert staff and so enhance the safety of the arrangement rather than the assessment of each resident and the needs and abilities that made this a safe and appropriate staffing arrangement for them. In addition there were possible risks that had not been identified and risk assessed.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had responded in a timely and systematic way to the risk posed to resident and staff health by the Covid 19 pandemic. There was a Covid team that led on the response and the response was informed by national guidance and updated as these guidelines changed, for example changes in the use of PPE and reduced restrictions on visitors to the centre. Staff had completed updated relevant training and residents had been spoken with as to the risk posed and the measures needed for their protection such as how to physically distance and completing hand hygiene. Staff and resident health was monitored each day. The premises was visibly clean with evident measures that supported effective infection prevention and control such as soap dispensers, disposable hand towels, pedal operated bins, hand sanitiser and face masks.

Judgment: Compliant

Regulation 28: Fire precautions

The frequency of simulated drills was inconsistent. Records of completed drills indicated that three had been completed in January 2019, one in October 2019 and none since. While all of these drills had been successful none reflected the changes in occupancy or tested the adequacy of the night time evacuation plan. There were two copies of the centres fire plan on file both indicated as reviewed in 2020, however details such as details of responsible persons and persons to be contacted in an emergency were incorrect on one and not picked up on on review. Diagrammatic or narrative instructions to guide staff so that they could quickly identify zones and the location of a possible fire in either apartment was still not in place having been requested at the time of the previous HIQA inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The personal plan reviewed by the inspector was detailed and individualized to the resident. The plan was reviewed and the inspector was satisfied that changes that resulted from review were incorporated into the plan and daily practice.

Judgment: Compliant

Regulation 6: Health care

Staff monitored resident health and well-being and ensured that residents had access to the clinicians and services that they needed to stay well and healthy. Residents were encouraged to make healthy lifestyle choices such as in relation to diet and exercise.

Judgment: Compliant

Regulation 7: Positive behavioural support

A plan of support informed by the appropriate clinician ensured that staff had evidence based guidance in understanding, preventing and responding to any behaviour of concern and risk.

Residents enjoyed minimal restrictions in their daily routines and there was a rationale for any interventions in place. However, the process of review did not demonstrate what the restrictive impact was, how this was considered and how the provider assured itself through review that the benefits outweighed possible impacts, promoted resident safety and so informed its ongoing use.

Judgment: Substantially compliant

Regulation 8: Protection

There were no reported safeguarding concerns. Staff had completed training and residents were supported to develop their awareness of and the skills needed for self-protection.

Judgment: Compliant

Regulation 9: Residents' rights

These inspection findings reflected a service where the individuality of each resident was respected and promoted. Residents were supported to have independence in their routines and opportunities for meaningful engagement including paid work in their community. Ongoing access to friends and family was part of life in the centre, there was recognition of the impact on residents as a consequence of the restrictions imposed to curb the spread of Covid 19 and measures to reduce the impact.

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 23: Governance and management	Substantially compliant
Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Newmarket Residential OSV-0005528

Inspection ID: MON-0029751

Date of inspection: 23/06/2020

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Review management systems in particular risk assessment and fire safety and how these are reviewed and information documented by the team. Regional Manager to supervise and mentor staff to promote continual development of services delivered and give clarity of roles and responsibilities. Regional Manager to update Service Lead and HSE where necessary of any changing needs in the service. Complete scheduled internal audits as part of internal quality control measure	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: Agree with tenants who they would like to help advocate for them on issues relating to service they receive.	
Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Complete review of hazard identification and risk assessments associated with the DC Review that items notified on OLIS have associated risk assessment completed where necessary.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Review fire precautions and provide training and guidance for staff by external trainer for both apartments during day and at night. Fire safety to be an agenda item at regular team meetings Put legend in place beside fire panel in Apt 37 to indicate where location of alarm in Apt 38 Ensure fire drills are planned and scheduled appropriately during the year.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: Review how individuals or their representatives can give informed consent for therapeutic interventions that will arise for tenants. Document and review this as part of individual personal processing process.	

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 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 to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	20/07/2020
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	20/07/2020
Regulation 26(1)(b)	The registered provider shall ensure that the risk management	Substantially Compliant	Yellow	20/07/2020

	policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the risks identified.			
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	29/06/2020
Regulation 28(3)(b)	The registered provider shall make adequate arrangements for giving warning of fires.	Not Compliant	Orange	26/06/2020
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	29/06/2020
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Substantially Compliant	Yellow	20/07/2020
Regulation 34(3)(a)	The registered provider shall nominate a person, other than the person nominated in paragraph 2(a), to be available to residents to ensure that: all complaints are appropriately	Substantially Compliant	Yellow	20/07/2020

	responded to.			
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Substantially Compliant	Yellow	20/07/2020