Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	St. John of God Kerry Services - Beaufort Campus Units Area 1
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Kerry
Type of inspection:	Short Notice Announced
Date of inspection:	13 October 2020 and 24 November 2020
Centre ID:	OSV-0003630
Fieldwork ID:	MON-0028693

About the designated centre

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

The designated centre provides residential full-time care to male and female adults within a large campus in a rural setting. The designated centre is registered to accommodate 26 residents but presently has 23 residents and is closed to further admissions. Residents have a range of moderate, severe and profound intellectual disability with complex medical care needs. Some residents have a dual diagnosis and high physical support needs. Accommodation is in four separate premises. Between five and seven residents reside in each premises. All accommodation is at ground floor level. All bedrooms are single occupancy bedrooms. The staff team comprises of nursing staff and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	23

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 13 October 2020	09:30hrs to 18:00hrs	Michael O'Sullivan	Lead
Tuesday 24 November 2020	09:00hrs to 17:00hrs	Michael O'Sullivan	Lead
Tuesday 13 October 2020	09:30hrs to 18:00hrs	Lucia Power	Support
Tuesday 24 November 2020	09:00hrs to 17:00hrs	Lucia Power	Support

What residents told us and what inspectors observed

First day of inspection 13 October 2020:

Of the 23 residents who lived in the designated centre, six residents were residing in a local hotel while essential fire works were undertaken within their home. An inspector met with 12 residents who were present at the designated centre. All of these residents communicated without words.

A number of residents had just returned from attending mass. Various other activities as planned and recorded on the activities board, had commenced. These included horticulture and sensory activation. Staffing support on a one-to-one basis was observed. All residents appeared happy and comfortable. Staff were observed to be respectful, gentle and all activities were unhurried. A number of residents were out walking or in wheelchairs in the grounds, supported by staff.

A significant change since the previous inspection was that all residents now had their own single occupancy bedroom. This afforded many residents additional space and these spaces were personalised to the occupant. Some new bedrooms that were recently constructed were now occupied. Plans were evident showing that some additional building works were planned to create larger bedrooms for some existing residents whose physical care needs and dependency levels had increased. One resident who had previously occupied a small bedroom had been supported to transition to a larger bedroom within the designated centre and appeared to have responded well to this change. Staff supports had accounted for a smooth transition.

The registered provider informed inspectors that families were aware of the inspection and that inspectors were on site on 13 October 2020. No families made contact with the inspectors on that date.

Second day of inspection 24th November 2020:

Inspectors returned to the designated centre unannounced, to pursue some lines of enquiry. The registered provider was asked to alert all families who had a resident living on the campus, of the inspectors presence with the registered provider putting in place a dedicated phone line so that families could make direct contact with the inspectors. The registered provider contacted families by email with eight families in total making contact on the day. Families stated that they were not aware of the previous inspection having taken place. The majority of families spoke of the high standard of care that staff provided to residents. Families were happy with the supports in place. Some families acknowledged that they consented to the spending of residents' monies on the provision of external therapies for their family member but no family was aware of the amount of money spent on external therapies.

Families were complimentary of the efforts that staff made to provide a meaningful

day and to also maintain family contact through direct visiting, transporting residents home and the use of information technology and mobile phones to aid communication. Some families expressed the view that they would rather see residents experience external activities off campus rather than multiple campus based activities where the resident may not have left their own bedroom. Families felt that the anticipation and enjoyment of a planned and supported activity that involved the resident leaving the campus, would be far more enjoyed and remembered. Some families stated that external activities were very dependent on staff resources but hoped that the employment of community activation staff would address this shortcoming.

Many families expressed concerns in relation to the current pandemic, the outbreak of COVID-19 within the campus and how it would or did impact on their family member. Concerns were also made in relation to the registered provider's communications regarding the possibility of handing the services to the Health Services Executive.

Capacity and capability

This was a follow up inspection to determine the level of compliance in relation to the registered provider's compliance plan response to the inspection in November 2019. Significant improvements were noted by the inspectors. It was evident that effective leadership and the delegation of actions across a number of managers had resulted in the registered provider addressing areas of previous non-compliance. A substantial amount of actions committed to in the registered provider's previous compliance plan had been achieved. Resources to recruit additional staff and to address outstanding fire and safety works had been received and applied. Fire and safety works were on schedule to be completed by the end of 2020. Staff competencies and experience were subject to an ongoing staff review that provided for staff relocation to best suit the assessed needs of residents.

A staff recruitment process had been undertaken and there were additional staff recruited. Additionally, three new staff were appointed in September 2020 to plan and support activities for residents. These staff were not included in the general provision of care to residents so that their function of supporting activities was protected. The inspectors reviewed the planned and actual staff rotas for the centre and these were in line with the numbers and skills mix necessary for the assessed needs of most residents. It was also noted that the provider had carried out a staffing review of current resources taking into account the profile of the current residents and their changing needs.

The provider had identified variances in relation to whole time equivalents that may be required to support enhanced care for residents and this piece of work was ongoing at the time of inspection. As identified on previous inspections in 2019, a nurse was allocated on night duty to one home with five residents who had

high assessed medical and physical needs. This nursing resource was only available on alternative weeks and nursing interventions required the attendance of a nurse employed in a separate designated centre on campus. In this instance, the inspectors were of the view that the nursing allocation did not meet the particular needs of these residents.

The provider in line with Regulation 23 Governance and Management had conducted an annual review of the quality and safety of care to residents. The provider had also carried out an unannounced visit to the centre at least every six months with plans put in place to address any concerns with identified actions and time lines. Internal audits in relation to fire and safety, adherence to the registered providers policies on the management of residents finances, policies and a personal outcome audit had also been conducted. Some of these audits were used by the provider to enhance the quality of service provided to residents.

However, it was evident from a sample of four residents' financial records that a significant amount of residents' personal funds were spent on a range of external therapies. The registered provider had a receipt system in place and this was reviewed by the inspectors on the first day of inspection. Local management were not aware of the amount of monies paid to external therapists. A review of all amounts of residents funds used to pay for reflexology, massage, gong and music therapy was requested by the inspectors and subsequently provided by the registered provider. This information was further examined on the second day of inspection.

The inspectors reviewed the cost of external therapies to residents in the centre and noted that these costs were very high based on the disposal income that residents had. The provider as requested by the Health Information and Quality Authority (HIQA), carried out an internal audit pertaining to the cost of all external therapies. A number of residents had spent in excess of €3000 over a one year period although there was an allowance waiver specific to massage but not for the other therapies. In one case the registered provider acted as guardian for the resident and there was no evidence of independent oversight in relation to the cost of the therapies or the residents' input in relation to same. It was also noted that the weekly activity schedule incorporated external therapies as part of the programme of activities. In some cases the number of paid external therapies on the weekly activity sheet exceeded what was provided for in the residents' financial passport. Twenty residents in this registered centre had availed of external therapies which totalled €26,805. The providers policy on resident finances did not include reference to external therapies and the cost to residents.

Inspectors were not assured that there were effective management systems in place to ensure that the service was appropriate to residents' needs with the significant amounts of residents' personal funds that were required for external therapies that accounted for resident activities. Supports were not in place in relation to residents' payment for external therapies and were not subject to annual review or accounted for in the registered provider's policy on residents' finances. It was not evident that each resident had access to and retained control over their finances in this regard. It was not apparent if support was provided to residents to manage their financial

affairs and the purchasing of such therapies. Nor was it evident whether the residents consented to such decisions. The cost of some of these therapies did not correlate with what was in the provider's statement of purpose and local management stated that this would be amended.

The registered provider had records that evidenced all staff had undertaken fire and safety training that was in date. Additional training in relation to fire and safety awareness had also been undertaken. All staff had received training in relation to safeguarding vulnerable adults. The provider had in place training for managing and preventing behaviours that challenge as well as multi-element behavioural support. This training was specific to the assessed needs of residents and the home they lived in. Additionally, staff had undertaken training in relation to infection control, hand hygiene and the use of personal protective equipment (PPE).

All notifications had been made to the Chief Inspector, within the required three day period. All reported incidents to the HIQA were consistent with the registered provider's records on the national incident management system (NIMS).

The inspectors reviewed a number of complaints that the registered provider had addressed since the previous inspection. The records reflected a prompt response by all staff to adequately deal with complaints to the satisfaction of the complainant. These records also evidenced a person centred approach where the rights of the resident were prioritised.

Regulation 15: Staffing

The registered provider ensured that the numbers, qualifications and skill mix of staff were appropriate to the number and assessed needs of most residents, however the alternating nurse resource at night time in one unit did not address the assessed needs of those residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The person in charge ensured that staff had access to appropriate training, including refresher training.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had made significant improvements to the management systems in place and additional resources had been secured to employ additional staff and address areas of regulatory non-compliance particularly in relation to fire safety. However, the management systems in place did not ensure services were appropriate to residents' assessed needs. The need to support residents to make an informed decision on the use of their personal funds to pay for external therapies were not subject to annual review.

Judgment: Not compliant

Regulation 31: Notification of incidents

All notifications had been made to the Chief Inspector within the required time frames as prescribed by the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The register provider had a complaints procedure in place that clearly demonstrated that complaints were dealt with effectively.

Judgment: Compliant

Quality and safety

The inspectors noted that there had been an overall improvement in the quality and safety of services since the last inspection. The focus of service delivery was more aligned with the needs of and the support of residents. Staff allocations were based on the assessed needs of residents and prior to the COVID-19 pandemic had focused on increasing residents' access to the wider community. The movement of residents within the service to avail of individual bedrooms was a significant development. Planned building and renovation works to address issues of fire and safety compliance were progressing to conclusion by the end of 2020.

On the previous inspection, significant fire and safety issues had been highlighted to the registered provider. In response, the registered provider had secured funding to address such areas. On the day of inspection, the registered provider had a schedule of completed and proposed fire works. This schedule indicated that the

registered provider would have all works completed by the end of 2020. It was evident that each house had a smaller number of residents than the previous inspection and all fire drill times reflected the safe evacuation of residents. Each resident had a clear and current personal emergency evacuation plan. Each house had a weekly fire checklist that staff adhered to. Staff practices were observed to be of a good standard - fire exits were clear, oxygen was properly and safely secured, doors were not wedged open and charging hoists were stored in rooms rather than under stairwells. A bedroom previously identified as a room within a room had planned works to come into fire compliance, despite the fact that the room no longer served as a bedroom. The fire alarm system, the emergency lighting system and all fire extinguishers had been serviced in the current year. All staff had undertaken mandatory fire and safety training as well as local induction and fire and safety awareness training.

The premises provided additional space to residents as a result of reduced resident numbers. All residents now had a single occupancy bedroom and plans were in place to create larger bedrooms for some residents. Bedroom spaces had been enhanced and there were additional efforts to personalise the residents' bedroom spaces. One resident who had previously occupied a small bedroom had been transitioned to a vacant larger bedroom. Staff familiar to the resident supported this transition. The premises overall was brighter, cleaner and all residents' files were noted to be stored securely. Additional outdoor musical instruments had been installed in the grounds and residents were observed enjoying the use of these with staff support. Areas for receiving visitors were clearly identified and protected as visiting spaces.

The activity records of all residents reviewed had reflected a significant improvement in the level of community based activities, prior to the start of the COVID-19 pandemic. The majority of community activities had opened up prior to the inspection, only to be restricted again in line with current national public health guidelines. The registered provider had recruited three additional social and recreational staff whose role was to support community activities for the residents and to work with other staff in the centre to promote community engagement. The impact of this engagement had yet to be seen as the staff were involved in planning the roll out of activities before public health guidelines delayed increased community access. It was evident from family feedback that it was difficult for residents to plan for activities based outside the campus as staff resources were frequently cited as the reason preventing such activities occurring. This impacted on residents general welfare and access to activities as well as limiting opportunities to pursue individual interests.

The inspectors reviewed the individual care plans and notes relating to five residents. Sadly, three of these residents had passed away since the previous inspection. The records maintained were to a good standard. All individual goals had been the subject of review. It was clear that all residents had been in receipt of regular health assessments and their health needs were reviewed by staff working within their homes as well as allied health professionals. These professional inputs were specific to the assessed physical and medical needs of the residents in question. Reviews were clearly documented and the response of staff to attend to

residents was immediate. Where representatives were unable to contribute to the residents' planning meetings, letters from the person in charge were sent to ensure family participation by seeking further involvement or any suggestions. All residents had a social story within their records explaining the works been undertaken to improve the environment they were living in. Where residents required positive behaviour support, there was evidence of specific support plans in place. The residents in this regard were supported by a positive behaviour support plan as well as by staff recording the residents' response to the plan. Through a process called the wheel of optimal living - residents were beginning to identify personal goals that had far more meaning to them. This process was in the early stages.

The health records and hospital passports of residents were reviewed on both days of inspection. All records were maintained to a high standard. Supports in place to support residents in outside hospitals were in line with current public health guidelines and there was evidence that the provider consulted clinicians in outside hospital to clarify a level of support required based on residents' needs and clinical direction. The level of supports agreed were consistent with the registered provider's protocol for supporting residents transferred to other hospitals.

On the first day of inspection, it was evident that staff had undertaken training in relation to the proper use of PPE. Staff had also undertaken educational modules in relation to proper hand washing and breaking the chain of infection. Stocks of PPE were held centrally on the campus and it was observed that significant stocks were in place. Hand sanitizer stations were located throughout all houses with staff and residents observed to use these effectively. All visitors to a house were required to sign in and have their temperature recorded by a member of staff. Staff allocations were monitored to ensure that there was limited crossover and contact between the staff in each house. A significant outbreak of COVID-19 had occurred within the designated centre since the first day of inspection. This had impacted significantly on residents and staff. In the intervening period, the registered provider had notified to HIQA a break in infection control procedures on site. It was evident that the registered provider had taken this breach extremely seriously. Staff were subsequently retrained in relation to infection control policies, had back to work interviews and all crossover of staff between units was closely monitored and kept to an essential minimum. Current public health guidelines were seen to be adhered to. On the second day of inspection, all residents that had been effected, were observed to be recovered and well.

Since the previous inspection the registered provider had undertaken a significant review of its risk register and risk assessment process. The risk register for the designated centre was very comprehensive and allowed drill down to the individual risk assessments for each resident which were current and reflected the COVID-19 pandemic.

Regulation 11: Visits

The person in charge ensured that a suitable and private place was available to receive visitors in the designated centre.

Judgment: Compliant

Regulation 13: General welfare and development

While the registered provider had increased facilities for residents to access community based activities prior to the commencement of the pandemic, the impact of additional recruited posts had yet to take place.

Judgment: Substantially compliant

Regulation 17: Premises

The registered provider had ensured that the premises was designed and laid out to meet the number and assessed needs of the residents.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider ensured that there were systems in place in the designated centre for the assessment, management and ongoing review of risk in the designated centre.

Judgment: Compliant

Regulation 27: Protection against infection

The registered provider had responded appropriately to an outbreak of COVID-19 in this designated centre with staff retrained, crossover of staff between units kept to a minimum and public health guidance adhered to.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had effective fire safety management systems in place, however the planned schedule of works to ensure the building fabric and building services complied with regulatory fire precautions were not complete at the time of this inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The person in charge ensured that each resident had a current care plan that reflected effectiveness and changes in circumstance and assessed needs.

Judgment: Compliant

Regulation 6: Health care

The registered provider had in place appropriate healthcare for all residents based on the residents' assessed needs.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' personal living spaces had greatly improved, however, residents' freedom to exercise choice and control over their daily lives remained limited to the campus they lived on.

Judgment: Substantially 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 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	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 9: Residents' rights	Substantially compliant

Compliance Plan for St. John of God Kerry Services - Beaufort Campus Units Area 1 OSV-0003630

Inspection ID: MON-0028693

Date of inspection: 13/10/2020 and 24/11/2020

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • A review of the units with the alternating nurse resource at night has taken place and the units will be re-configured to be part of one Designated Centre as part of the registration application in 2021. Completion date : 30/07/2021	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Regulation 23(1)(a)(c) : Community based activities and actions will be implemented and restricted in line with the relevant public health guidelines relating to COVID 19 and the national restriction level in place at any given time. • Therapies will be sourced in the community in the first instance as part of resident's activities once national COVID 19 restrictions allow. A review of each resident's participation in therapies will take place and identify if this activity can be pursued in the community. Completion Date: 30/03/2021 • As per findings of the finance review carried out in October regarding resident's expenditure on external therapists, the registered provider will arrange for each family / representative to be notified of the findings of this review including an account of what the individual has spent on such therapies.	

Completion Date: 31/01/2021
• Prior to the recommencement of any campus based therapies a financial will and preference document will be completed in consultation with the resident and their circle of support outlining the proposed annual cost of therapies.
Completion Date:30/06/2021

• Financial Will and preference document will be completed in consultation with the resident and their circle of support outlining the proposed annual cost of therapies identified as part of the residents personal planning meeting.
This will be implemented in line with the schedule of the residents Annual Planning meeting.
Completion Date : 30/12/2021

• As part of the annual audit schedule the PIC will ensure an audit is completed of the resident's financial passports.
Completion Date : 28/02/2021

• A review of the Local Finance Procedure to be completed to include reference to external therapies and reflect the option of residents accessing same.
Completion Date : 30/04/2021

• The Statement of Purpose has been updated to clarify costs of therapies to residents.
Completed : 11/12/2020

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
Regulation 13(2)(a)(b)(c) :

• Social and Recreational support staff are in place and will resume individual community based activities in line with current national public health guidelines. A log of activities to monitor the implementation of the programme will be furnished to PIC monthly and Jointly reviewed in consultation with team
Completed : 30/05/2021

• Current campus based activities will be identified as part of the resident's individual planning process to determine if they are in line with resident's needs. Alternative community based options will be identified to provide residents with increased opportunities for community activity.

Completion Date: 30/09/2021

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Regulation 28(2)(b)(i) 28(3)(a)

• A planned schedule of works to ensure the building fabric and building services compiled with regulatory Fire precautions is in place. There is one item of work outstanding due to the delayed delivery of products, this will now will be completed by 26/02/2021.

Completion Date: 26/02/2021

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Regulation 9(2)(b)

• Current campus based activities will be identified as part of the resident's individual planning process to determine if they are in line with resident's needs. Alternative community based options will be identified to provide residents with increased opportunities for community activity.

Completion Date 30/09/2021

• The PIC will review the community based activity with the CNM2 manager per location on a quarterly basis as part of the PIC/CNM2 meeting to identify current implementation levels, Progress and challenges in the location. Actions identified to improve implementation will be included and monitored in the unit plan

Completion Date 15/03/2021

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 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Substantially Compliant	Yellow	30/09/2021
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	30/09/2021
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with	Substantially Compliant	Yellow	30/09/2021

	their wishes.			
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Substantially Compliant	Yellow	30/07/2021
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	31/12/2021
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 to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/12/2021
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	26/02/2021
Regulation 28(3)(a)	The registered provider shall make adequate	Not Compliant	Orange	26/02/2021

	arrangements for detecting, containing and extinguishing fires.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Substantially Compliant	Yellow	30/09/2021