



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

Issued by the Chief Inspector

Name of designated centre:	36 Elmwood Park
Name of provider:	St Michael's House
Address of centre:	Co. Dublin
Type of inspection:	Announced
Date of inspection:	16 February 2022
Centre ID:	OSV-0002392
Fieldwork ID:	MON-0027463

About the designated centre

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

Elmwood provides residential care and support to adults with an intellectual disability. Residents with additional physical or sensory support needs can be accommodated in this designated centre. Elmwood can support residents with additional support needs such as alternative communication needs, specialist diet and nutrition programmes and residents with well managed health conditions such as epilepsy or diabetes. The centre can also support people with dual diagnosis intellectual disability and mental health diagnosis.

Elmwood offers support to residents in activities of daily living including support in personal care, meal preparation, organising, planning and participating in social activities. Multi-disciplinary support is available to assess and support residents' changing needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:

6

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 16 February 2022	10:40hrs to 18:00hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

In line with public health guidance, the inspector wore a face mask and maintained physical distancing as much as possible during interactions with residents and staff. The inspector had the opportunity to meet five of the residents on the day of the inspection. Three of the residents spoke to the inspector about their experiences of living in Elmwood.

The inspector used observations, discussions with residents and key staff and a review of documentation to form judgments on the quality of residents' lives in their home. Overall, the inspector found that the designated centre was striving to provide a person-centred, quality service which was respectful of residents' rights, needs and wishes. The inspector saw that residents appeared comfortable and relaxed in their home and that they had access to wide range of meaningful activities and opportunities both at home and in the community.

On arrival to the centre, the inspector saw that residents were supported to engage in activities of their choosing for the day. Some residents had already left to attend day service, either travelling independently or with support, as per their assessed needs. Another resident was preparing to attend a community-based art class. Two residents chose to remain in the centre. One was engaged in their preferred activity while another had chosen to have a lie-in that morning. The person in charge explained that some residents had retired from day service or were semi-retired and so preferred a more relaxed pace of life.

A schedule of chosen activities for the week, for each resident, was available in the kitchen. The schedule was driven by residents' identified goals for 2022 and was meaningful and person-centred. For example, some residents' goals included going out for tea every day or going swimming or to the hair salon once a week. Opportunities to achieve these goals were included on the weekly schedule.

In addition to resident goals, the person in charge and staff team had put together their own goals for the service for 2022. These were displayed in the kitchen and centred around ensuring that residents' were supported to receive person-centred care which was respectful of their rights, needs and wishes.

The atmosphere in the designated centre was relaxed. Staff were observed to interact with residents in a familiar and friendly manner. Staff communication, when supporting residents, was positive and encouraging. The inspector saw staff consulting with residents, keeping them informed of what was going on in the house and requesting permission to enter resident bedrooms or to show the inspector their personal plans.

The inspector observed that the designated centre was clean and tidy. Residents had access to their own bedrooms, two sitting rooms, a large kitchen and dining room and enclosed garden which was welcoming. A shed in the back garden was

used to store assistive equipment when not in use. The centre had recently been painted and was decorated with resident photographs and artwork. Several residents showed the inspector their bedrooms and told the inspector that they had chosen the paint colour and were happy with how they were decorated.

Accessible documentation was available throughout the centre, including procedures for making a complaint, fire evacuation plans and COVID-19 awareness information. There was a visual menu available in the kitchen which showed the meals for the week. Residents spoken with stated that they were involved in choosing meals and that they were happy with the food choices available in the centre. Residents told the inspector that they generally get on well together. However, some residents said that, at times, due to one residents' needs, it can be noisy at night time. The inspector saw that the provider had put in place an accessible complaints form, and that where complaints were made, that these were resolved to the satisfaction of the residents. Residents spoken with were aware of how to make a complaint. The provider had also introduced measures such as allocating additional staffing and moving resident bedrooms to further reduce the impact of any peer compatibility issues. This will be discussed further in the Quality and Safety section of the report.

Overall, the inspector found that the residents in this centre were supported to enjoy a good quality of life which was respectful of their rights and wishes. The person in charge and staff were striving to ensure that residents lived in a supportive environment and were consulted in the running of the centre in a meaningful way.

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

Capacity and capability

The purpose of this inspection was to monitor ongoing levels of compliance with the regulations. The inspector found that this designated centre met and exceeded the requirements of the regulations in many areas of service provision.

There were effective management arrangements in place that ensured the safety and quality of the service was consistently monitored. The provider had systems in place to review the quality of services such as bi-annual, unannounced visits and an annual review of the quality and safety of care. The annual review clearly set out how the views of residents, family members and staff were captured in order to inform goal setting. A time-bound action plan was derived from the annual review.

The centre had a clearly defined management structure, which identified lines of authority and accountability. There was a person in charge employed in a full-time capacity, who had the necessary experience and qualifications to effectively manage

the service. The person in charge had oversight solely of this designated centre. The person in charge was supported on site but a social care worker who assisted in the management of the service. The person in charge and social care worker had access to allocated management hours which were detailed on the roster. The person in charge was further supported in their role by a service manager.

A planned and actual roster were maintained for the designated centre. A review of the roster demonstrated that staffing levels and skill mix were appropriate to meet the assessed needs of the residents. There was evidence that the person in charge had completed risk assessments based on residents' changing needs as appropriate and that the provider had responded by allocating additional staffing with the required skills and qualifications. For example, a staff nurse was added to the roster several years ago based on the changing age demographic of residents and an increased need for nursing care. In the past year, a business case was submitted in order to provide one-to-one support for a resident based on their assessed needs. The business case was approved and the roster and statement of purpose reflected the increase in whole time equivalent staffing allocation for the centre. The provider attributed a reduction in peer to peer related incidents to the addition of this staff to the roster.

The centre was operating with one whole time equivalent staffing vacancy at the time of inspection. The service provider was endeavouring to ensure continuity of care for residents by covering this vacancy by a small panel of relief staff. The schedule 2 records were reviewed for two members of staff. This review demonstrated that all of the relevant documents and information as required by the regulations were maintained in respect of these staff.

A review of the staff training matrix identified that staff had access to a high level of mandatory and refresher training. There were some identified gaps in the delivery of face-to-face refresher training. This training had been delayed due to COVID-19. The inspector was informed that the provider was in the process of securing dates for this refresher training. Staff also had access to frequent supervision, the content of which was appropriate to meet their needs. Most staff had received three supervisions in 2021. The provider's policy set out that four supervisions should be completed annually however, the inspector was informed that there was difficulty achieving this due to COVID-19 related staff absences. A supervision schedule was in place for 2022. Staff spoken with told the inspector that they felt supported in their role.

The centre's statement of purpose was reviewed. It was found to have been recently updated and contained all of the information as required by Schedule 1 of the regulations.

The provider had effected a contract of insurance against injury to residents and had submitted a copy of their insurance policy to support the application for renewal of the centre's certificate of registration.

Regulation 14: Persons in charge

There was a person in charge of the centre who was a qualified professional with experience of working and managing services for people with disabilities. They were found to be aware of their legal remit with regard to the regulations, and were responsive to the inspection process. The person in charge was employed on a full-time basis and had responsibility for the oversight of solely this designated centre.

Judgment: Compliant

Regulation 15: Staffing

The qualifications and skill mix of staff were appropriate to the number and assessed needs of the residents. The provider had responded to residents' changing needs by recruiting nursing staff and increasing the whole time equivalent of staff to provide an individualised service to one resident who required this.

There was one whole time equivalent vacancy for a social care worker at the time of inspection. The provider was utilising a small panel of regular relief staff to fill this gap. This supported continuity of care for residents. A planned and actual roster was maintained for the service. The schedule 2 files for two staff were reviewed and were found to contain all of the required documentation.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There was a system in place to evaluate staff training needs. There was generally a high level of mandatory and refresher training maintained in the designated centre. Education and training had been provided to staff which enabled them to provide care that reflected up-to-date, evidence based best practice. There were some gaps identified in training which was required to be delivered face-to-face. The provider informed the inspector that dates would be secured for these in the coming weeks. The outstanding refresher training required included:

- first aid: 4 staff required this. A date had been secured for one of these staff
- Therapeutic intervention practices: all staff required refresher training. The provider stated this would be completed in March 2022
- Bed evacuation: all staff required refresher training. A date was secured for 04 March 2022

Staff had access to regular quality supervision, the content of this was appropriate

to their role. Staff had not received supervision at the frequency as set out in the provider's policy. This was attributed to issues with scheduling supervisions due to COVID-19 related leave. The person in charge also had access to their own regular supervision. Staff spoken with stated they felt supported in their role.

Judgment: Substantially compliant

Regulation 22: Insurance

The provider had effected a contract of insurance against injury to residents and had submitted a copy of this to the Chief Inspector with their application to renew the registration of the designated centre.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined governance structure that facilitated the delivery of good quality care that was routinely monitored and evaluated. An annual review had been completed in consultation with residents, families and staff. Goals were identified from this review which were specific, measurable and time-bound. Additional audits such as biannual and unannounced hygiene audits further added to the oversight of the designated centre. There was evidence that actions identified as a result of audits were progressed in a timely manner and were being used to drive continuous service improvement.

The centre was managed by a suitably qualified person in charge who knew the residents well. The person in charge was responsive to the changing needs of residents and escalated concerns so that risks could be responded to in a timely manner. There were clearly defined local reporting arrangements. Staff were aware of their roles and responsibilities and of the reporting structure in the designated centre. Staff spoke positively about the governance and management arrangements and were aware of how to raise concerns if necessary.

Judgment: Compliant

Regulation 3: Statement of purpose

A statement of purpose was in place for the designated centre. The statement of purpose was found to contain all of the information as required by Schedule 1 of the

regulations. The statement of purpose had been recently reviewed and updated, and was located in an accessible place in the designated centre.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had in place a complaints policy for the centre. An easy-to-read version of the complaints procedure was located in an accessible place. The complaints policy and procedure included information for residents on how to access advocacy services. Residents spoken with were aware of the complaints procedure and knew how to make a complaint. There was evidence that where complaints were made that these were investigated promptly and that the complainant was informed of the outcome of their complaint. Measures, such as additional staffing or relocation of resident bedrooms were implemented to address recent complaints. A record of all complaints was maintained in the centre. On review of the complaints log, there was evidence that measures implemented were effective at reducing the frequency and impact of peer compatibility issues.

Judgment: Compliant

Quality and safety

This section of the report details the quality and safety of service for the residents who lived in the designated centre. Overall, the inspector found that the day-to-day practice within this centre ensured that residents were safe and were receiving a good quality and person-centred service. However, improvements were required to the fire evacuation procedures to ensure that all residents could be safely evacuated.

The designated centre was located in a residential area with easy access to public transport, shops and community facilities. Residents were seen to avail of these facilities on the day of inspection. The centre also had its own allocated bus which was available to support residents as per their needs and wishes. The premises of Elmwood was clean, suitably decorated and maintained in a good state of repair, both internally and externally. Residents had access to a large back garden which was welcoming and was equipped with a table and chairs for relaxation. Assistive equipment was available as per residents' assessed needs including height adjustable beds, wheelchairs and a Parker bath. There were sufficient bathrooms which were designed and equipped to meet residents needs. Resident bedrooms had recently been painted. Several residents showed the inspector their bedrooms and stated that they were pleased with how they were decorated. Residents were

observed freely accessing all parts of the centre including the two sitting rooms, the kitchen, utility and their bedrooms.

The provider had prepared a residents' guide which had been made accessible and contained information relating to the service. This information included the facilities available in the centre, the terms and conditions of residency, information on the running of the centre and the complaints procedure. An easy read contract of care was also located in resident files which detailed their tenancy agreements.

The provider had taken measures to mitigate against the risk of residents contracting a healthcare associated infection. The house was observed to be very clean and tidy. Staff were wearing PPE which was in line with current public health guidance. Temperature checks were maintained of all visitors to the centre and there was a high availability of hand sanitisation stations throughout the building. There was a one way flow of traffic identified for visitors to enter and leave the building and there were appropriate facilities for disposal of used PPE on leaving the centre.

An infection prevention and control (IPC) audit was recently completed by the provider. This audit identified that there was generally a high standard of environmental cleanliness, hand hygiene and cleaning of equipment and linen in the centre. The IPC audit identified several actions and there was evidence that many of these had been addressed by the person in charge by the time of inspection. Some actions remained outstanding. For example, the countertop in the kitchen required replacing as it was worn and therefore could not be adequately sanitised. The inspector also saw that the laminate on two kitchen presses had begun to peel away which presented a further IPC risk. The provider had a time bound plan in place to address the risks identified in the kitchen.

The provider had in place precautions against the risk of fire and had made arrangements for detecting, containing and extinguishing fires. All staff had completed fire safety training and regular fire safety checks were carried out. Regular fire drills were completed which simulated both day and night time evacuations. An emergency file was maintained which included up-to-date personal evacuation plans. Staff spoken with were knowledgeable regarding the evacuation procedures. However, it was found that evacuation procedures in the centre were not adequate to ensure the safety of all residents. A review of the fire drills demonstrated that one resident consistently failed to evacuate at night time. While the person in charge stated that this had been risk assessed previously and reviewed by the fire officer, this risk assessment was not available in the centre on the day of inspection. The measures in place to ensure this resident could be safely evacuated required review.

A review of resident files showed that the person in charge had ensured that a comprehensive assessment of need was completed for all residents which was regularly updated. Care plans were informed by this assessment of need and outlined the supports required to maximise residents' personal development. Personal plans were created through a person centred approach and goals were identified through consultation with residents and their representatives. Residents

spoken with were aware of their goals and there was evidence that goals were progressed through regular planning and support.

The designated centre was suitable for meeting the assessed needs of the residents. Residents had access to assistive equipment and nursing support as per their assessed needs. It was evident that residents had access to a variety of health care professionals as required including ophthalmology, dietetics, neurology, psychology and psychiatry.

There were several restrictive practices in place in the centre. These had been risk assessed to include the impact of restrictive practices on all residents, and not just the residents for whom they were implemented to protect. Restrictive practices were reviewed locally on a regular basis and annually by the provider's rights committee. Behaviour support plans were available for those residents who required them. These had been recently reviewed and updated and were written in person-centred language. Behaviour support plans detailed proactive and reactive strategies to support behaviour in line with evidence based, best practice. All staff had completed training in managing behaviour that is challenging.

There were systems in place to ensure that residents were protected from harm. All staff had completed training in safeguarding vulnerable adults and Children First. There were no active safeguarding concerns in the centre at the time of inspection. Intimate care plans were in place where required and were written in person-centred language. Intimate care plans detailed how staff support residents' dignity and autonomy.

Regulation 17: Premises

The registered provider had ensured that the premises was designed and laid out to meet the aims and objectives of the service and the number and needs of residents. The centre was maintained in a good state of repair and was clean and suitably decorated. Residents had access to facilities which were maintained in good working order. Assistive technology, aids and appliances were available as per residents' assessed needs. There was adequate private and communal space for residents as well as suitable storage facilities. The registered provider had made provision for the matters as set out in Schedule 6 of the regulations.

Judgment: Compliant

Regulation 20: Information for residents

A residents' guide was available in the designated centre which included all of the information as required by the regulations.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had effected policies and procedures to reduce the risk of residents contracting a healthcare associated infection. The centre was clean and tidy, staff were wearing appropriate PPE and good hand hygiene practices were observed.

An IPC audit had been completed which set out that a high standard of cleanliness was maintained in the centre. A SMART action plan was developed from this audit and there was evidence that the provider had completed some of these actions by the time of inspection and was in the process of implementing actions to address other risks.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had systems in place to detect, give warning of, and contain fires. All staff had completed fire safety training and staff spoken with were aware of evacuation procedures. Regular day and night time drills were completed.

However, the provider could not demonstrate that they had effective systems in place to ensure that all residents could be evacuated if necessary and brought to a safe location. There was an absence of risk assessments to support the evacuation plan for one resident who regularly refused to evacuate during night-time drills.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspector found that there was a system in place for assessing residents' needs and for ensuring that comprehensive care plans were in place to meet those needs. On a review of residents' files, the inspector saw that support plans were in place for each assessed need and that these support plans were updated at least annually. There was evidence that care plans were created in a person-centred manner and included meaningful and individualised goals.

An addition of a whole time equivalent staff as well as a reconfiguration of resident bedrooms, based on residents' assessed needs and their expressed preferences, had reduced the impact of peer compatibility issues. The inspector was assured on the

day of inspection that the designated centre was suitable to meet the needs of all residents as assessed.

Judgment: Compliant

Regulation 6: Health care

The provider had ensured that residents had access to appropriate health care. residents' care plans detailed access to a variety of health care professionals as required.

Judgment: Compliant

Regulation 7: Positive behavioural support

Staff had up-to-date knowledge and skills to respond to behaviour that is challenging and to support residents to manage their behaviour. Behaviour support plans were available for those residents who required them and were up-to-date and written in a person centred manner. Restrictive practices were reviewed locally on a regular basis and annually by the provider's rights committee. The person in charge was actively working to reduce the frequency of restrictive practices being used and had risk assessed the impact of a restrictive practice on all residents in the designated centre.

Judgment: Compliant

Regulation 8: Protection

The person in charge and their team had a good understanding of their responsibility to safeguard residents from all forms of abuse. Staff had completed training in safeguarding. Intimate care plans were up-to-date and were written in person-centred language which set out how staff should ensure residents' dignity and autonomy was respected. Staff were observed interacting with residents in a respectful manner.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for 36 Elmwood Park OSV-0002392

Inspection ID: MON-0027463

Date of inspection: 16/02/2022

Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant** - A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.
- **Not compliant** - A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing: In response to substantially compliant regulation 15 (1) at an organizational level recruitment drives are continuous.</p> <p>PIC and PPIM continues to complete the roster in a timely manner including regular relief to cover any gaps left by vacancies to ensure a consistent service is provided for all residents in Elmwood</p>	
Regulation 16: Training and staff development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>In response to substantially compliant regulation 16(1)(a) Staff Education, Training and Development Department have developed a plan to address staff training deficits. Planned schedule in place with Centre and training department to complete minimum training requirements by 31/06/22</p> <p>In response to substantially compliant regulation 16(1) (b) The person in charge will ensure that staff are appropriately supervised. The person in charge has planned all staff supervision for 2022. Completed 01/01/2022</p>	
Regulation 28: Fire precautions	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions: In response to substantially compliant regulation 28 3 (d) A high level risk assessment will be completed regarding the service users likely non compliance in an evacuation. This will involve a multi disciplinary approach to ensure all aspects have been considered as at its core it is a behavioural presentation in a fire evacuation.</p>	

This risk assessment will be provided to the senior management team to see if the organisation is willing to accept the risk given all measures in place to prevent a fire and protect the service user if one arose. It will also capture the effectiveness of the measures trialled. Planned completion date 31/04/22

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	30/09/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/06/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	01/01/2022

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.	Substantially Compliant	Yellow	30/04/2022
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