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:	Logan House
Name of provider:	The Rehab Group
Address of centre:	Galway
Type of inspection:	Announced
Date of inspection:	09 November 2021
Centre ID:	OSV-0003468
Fieldwork ID:	MON-0032875

About the designated centre

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

Logan House is a designated centre run by The Rehab Group. The centre can cater for up to seven male and female residents, who are over the age of 18 years and who have an intellectual disability. This centre can also cater for the needs of people with an acquired brain injury. The centre is situated on the outskirts of Galway city and is centrally located to cafes, restaurants and other local amenities. The centre comprises of one building which contains staff offices and five separate apartments. Here, residents have their own bedroom, some en-suite facilities, bathrooms and kitchen and living areas. A communal courtyard is also available to residents to use as they wish. Staff are on duty both day and night to support the residents who live here.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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 (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 9 November 2021	10:00hrs to 16:10hrs	Anne Marie Byrne	Lead
Tuesday 9 November 2021	10:00hrs to 16:10hrs	Aonghus Hourihane	Support

What residents told us and what inspectors observed

Overall, inspectors found that this was a well-run and well-managed centre, that was very considerate to the assessed needs and to residents' preferred lifestyles, ensuring residents received the type of service they required.

The centre comprised of one building, comprising of staff offices and five apartments. Some of these apartments were occupied by one resident, while others could cater for up to two residents. Each resident had their own bedroom, some en-suite facilities, bathrooms and kitchen and living area. The facility of a communal courtyard was also available, which comprised of a designated smoking area for residents who wished to smoke. Residents were supported to decorate their apartment to their own preference, with many spending time in their apartment during the day and night, independent of staff support. Due consideration was given to the layout of apartments occupied by residents with mobility needs. For example, in these apartments, inspectors observed lower kitchen counter tops, ensuring residents could easily access sinks and items on worktops. Wall mounted kitchen cabinets also had built in features, which allowed these residents to access items within these cabinets. These apartments were also fitted with an intercom system, which meant these residents could alert staff when they needed assistance. Low level touch points were also available, which allowed these residents to independently open all doors within their apartment. Staff were very respectful of residents' privacy and preferred way of living in their apartment and were very responsive to residents, should they require support in their apartment throughout the day and night.

Upon the inspectors' arrival to the centre, there was a very calm and relaxed atmosphere where residents were being supported with their morning routines. Inspectors had the opportunity to meet with four residents who lived at this centre. Other residents had already left for their day services, while others held employment within the community. One resident was leaving the centre for the day and briefly met with inspectors in their hallway. They had a key to their own bedroom and had their own personal key to lock their bedroom, which the person in charge told inspectors, was something that this resident liked to do. Another resident spoke directly with inspectors about the care and support that they received. They told inspectors that they had recently transitioned to their apartment and were getting on well. Along with an intercom system, they also wore a pendant alarm, which they could use, should they require staff support. This resident led a very active lifestyle and told inspectors of their plans to attend an upcoming rugby game. They also spoke of the allocated hours each day where they received staff support and remained independent of this support for the remainder of the day, unless their needs dictated otherwise. The two other residents who were in the centre had one-to-one staff support place; however, due their needs, they didn't engage directly with the inspectors. One of these residents briefly greeted inspectors upon their arrival to the centre, while the other resident was in the middle of their morning

routine with staff.

These residents led very active lifestyles and regularly accessed their local community independent of staff support. Some held employment, while others attended local day services. Although there was staff support at all times in the centre, many of these residents didn't require full-time staff support and were independent with many of their needs. Specific supervision arrangements were in place for these residents, whereby staff would regularly check in with them, while also being respectful of their right to be as independent as possible. Along with the centre's own transport, residents also had access to taxi and local transport services. Residents enjoyed accessing their local community as much as possible to go shopping etc. Where residents required staff support to do so, staff told the inspector that they planned their day around what residents wanted to do in the evening time, to ensure that these residents could get out and about. A staff roster was displayed in each apartment, which kept residents informed of which staff member was on duty that evening to support them, should they wish to head out.

Many of the staff who worked in this centre had done so for quite some time and were very familiar with the residents and their assessed needs. The provider was responsive in ensuring each resident had access to the level of staff support that they required. For example, in response to a safeguarding incident, it was identified that some residents would benefit from one-to-one support for intervals throughout the day and this was put in place and was working well. Of the staff members who met with the inspectors, they were very aware of the current risks in the centre and spoke at length about the care and support needs of residents. Overall, the inspectors observed staff interactions with residents were observed to be respectful, supportive and kind.

The next two sections of the report identify the findings of this inspection.

Capacity and capability

The purpose of this inspection was to monitor compliance with the regulations. Although the provider was found to be in compliance with many of the regulations, some improvement was required to aspects of governance and management, risk management, behaviour support and premises.

The person in charge held the overall responsibility for this centre and she was supported by team leaders, her staff team and line manager in the running and management of the service. She held very good knowledge of each resident's assessed needs and of the operational needs of the service delivered to them. She was regularly present at the centre to meet with staff and residents, which greatly enhanced her oversight of the quality and safety of care. This was the only designated centre operated by the provider in which she was responsible for and current support arrangements gave her the capacity to ensure the service was

effectively managed.

The centre's staffing arrangement was subject to regular review, ensuring a suitable number and skill-mix of staff were on duty to meet the assessed needs of residents. Some residents didn't required full-time staff support and arrangements were put in place to ensure these residents could live independent of staff support with aspects of their daily lives. Specific supervision arrangements were in place for these residents, where staff engaged with them throughout the day, should they require support. To support the centre's staffing levels, regular agency staff were often rostered on duty. The person in charge spoke with the inspectors about this arrangement and about the efforts made by the provider to ensure consistency of care for residents. For example, regular agency staff were only availed of to support these residents and arrangements were put in place to ensure these staff were given a comprehensive handover, to ensure they were updated on any changes to residents' care needs. The use of agency staff was also regularly discussed with staff as part of staff team meetings to identify if any issues were arising. For example, for one resident, this resident had requested that they were to be only supported by a regular staff member and all efforts were made to ensure this arrangement was in place for this resident.

The person in charge had a training matrix which evidenced that the core staff team had received mandatory training. The matrix was not a reliable source for the provider to assure themselves that training was up to date as some training such as fire safety was missing from it. On the day of inspection, it was observed that a staff member was completing training online and this staff member reported that training was taking place on a regular basis both in person and on-line. They reported that training was important to them and that it was discussed with their team leader at each supervision. It was also noted that the provider had plans to ensure that all staff had completed neurological support training by the end of 2021. This was progressive and responsive given the particular needs of the residents within the centre.

The person in charge carried out regular audits and the learning from these were shared with staff at team meetings. The provider had carried out an annual review and also there was a 6 monthly audit of the safety and quality within the centre. The annual review and 6 monthly audit were focused and did point to some areas for improvement. The annual review had very limited input from representatives of the residents and there was no evidence of feedback from the residents. The person in charge assured the inspectors that feedback forms were completed and the review mentioned that the document would be updated later in the year with the residents views.

The inspectors saw evidence that the staff team had regular team meetings and reviewing the minutes it was clear that the agenda for these offer all staff the opportunity to be kept up to date with all developments within the centre.

The provider had ensured that there were basic systems in place to assure themselves that the service they provided was safe and of a good quality. The provider needed to finesse and enhance these systems, this will be discussed later in

the report particularly in relation to management of risk and behavioural support. The provider also needs to explicitly ascertain the views of residents and their representatives when they are completing the annual review.

Regulation 14: Persons in charge

The person in charge held the overall responsibility for this centre and she was found to have very good knowledge of residents' care needs and of the operational needs of the service delivered to them.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels were appropriate to meet the assessed needs of the residents. The provider used agency staff when necessary but had protocols in place to ensure consistency of agency staff.

Judgment: Compliant

Regulation 16: Training and staff development

The staff team engaged in regular mandatory training both on-line and in person. The provider had plans for all staff to be trained in neurological support training by the end of 2021 and this was appropriate given the profile of residents accommodated.

Judgment: Compliant

Regulation 23: Governance and management

The provider had ensured that systems relating to governance and management were operating within the centre. The provider needed to enhance their management systems to effectively assure themselves that the service offered was consistently safe and effective. The provider further needed to enhance their engagement with residents and their representatives when they are completing their annual review and ensure that their views are evidenced in the review.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge had systems in place to ensure all incidents were notified to the Chief Inspector of Social Services, as required by the regulations.

Judgment: Compliant

Quality and safety

This centre was operated in a manner that promoted a person-centred approach to the care delivered to residents.

The centre comprised of one building, which contained staff offices and five separate apartments. Some of these apartments were single occupancy, while others accommodated up to two residents. Each resident had their own bedroom, some en-suite facilities, bathrooms and kitchen and living area. Each apartment was visited by the inspectors and found to be decorated in manner that was to the preference of each resident. Residents proudly displayed photographs in their apartment and where residents had mobility needs, consideration was given to the design and layout of their apartment to ensure they could access all areas of their kitchen, as well as having low-level touch access points to open doors. Some apartments had intercom systems, which residents could use to alert staff, should they required assistance. A communal courtyard was available to residents to use as they wished, with a designated smoking shelter available to residents who smoked. Although the centre provided residents with a comfortable living environment, during the walk-around of the centre, the inspectors observed many areas would benefit from maintenance and re-decoration works.

Systems were in place for the re-assessment of residents' needs and staff were very responsive to liaise with relevant allied health care professionals, with regards to residents' changing needs, as and when required. Some residents were very independent with caring for their own health care needs and staff were aware of their role and responsibilities in supporting these residents. Some residents had only recently transitioned to the centre and staff told the inspectors that this transition had gone very well and that they were getting on well with their peers.

Similar arrangements were in place for residents who required positive behaviour support. Both the person in charge and staff told the inspectors that some residents had recently experienced increased behaviour related incidents and spoke of the response to this, which included, additional multi-disciplinary input and increased

staff supervision and support. To date, this was working well and behaviour related incidents with regards to these residents, were recorded and trended on a very regular basis to inform multi-disciplinary review. Interim behaviour support plans were made available to staff to guide them on the current support required by these residents. The person in charge told the inspectors that she was expecting final versions of these documents to be available to staff subsequent to this inspection. A number of incident reports relating to behavioural management were reviewed by the inspectors, and it was identified that staff regularly were required to respond to specific behaviours of another resident, which may pose a potential risk or have a negative impact to female staff members. Some staff spoke with the inspector about the specific behaviours that this resident exhibited and were very knowledgeable of how to respond therapeutically to these. However, although there was a very good incident reporting system around these incidents, on review of the behaviour support plan for this resident, it failed to adequately guide staff on what to do, should these incidents occur where only female staff were working in the centre to respond to them.

The provider had ensured fire safety precautions were in place, including, fire detection arrangements, regular fire safety checks and fire safety training for all staff. A waking night time staffing arrangement was in place, meaning that should a fire occur at night, staff were available to quickly respond to it. During a walk-around of the centre, the inspectors noticed some maintenance works were required to self-closing fire doors. This was brought to the attention of the person in charge, who put immediate measures in place to ensure interim fire containment arrangements were in place, until these fire upgrade works were completed. Regular fire drills were occurring and records of these drills demonstrated that staff could effectively support residents to evacuate the centre in a timely manner. Plans were also in place to complete a fire drill using minimum staffing levels, subsequent to this inspection. Multiple fire exits were available, including upstairs fire escape routes for those residing in upstairs accommodation. Although there was a fire procedure available, it required further review to staff with clarity on the specific response to fire at the centre.

The identification of risk in this centre was largely attributed to the provider's robust incident reporting system, staff handover and regular presence of the person in charge at the centre. Staff were vigilant in the reporting of incidents and the trending of these greatly informed risk management activities required in response to risks identified. For example, in response to behaviour related incidents, which identified changes to some residents' behavioural support needs, adequate support and review arrangements were put in place to mitigate against any further risk to these residents. A similar response by the provider was also evident where peer to peer incidents had occurred, with additional measures put in place to protect the safety and welfare of all residents involved. A number of risk assessments were reviewed by the inspectors as part of this inspection, and although much effort was made to ensure these were reviewed on a regular basis, improvement was required with regards to ensuring better hazard identification, clearer identification of measures put in place and accuracy in risk rating. For example, for one resident, it was observed that multiple risks relating to them were amalgamated on a single risk assessment. Although this risk assessment did identify control measures, as multiple

risks were identified on this one risk assessment, it was unclear which measures were put in place in response to individual risks, therefore impacting on the provider's ability to accurately risk rate each risk. With regards to organisational risk, these too were responded to in a timely manner and reviewed on a regular basis by the person in charge. However, some organisational risks did not have a supporting risk assessment in place to support her in doing so. For example, specific risks relating to the centre's staffing levels and potential risks relating to female staff working in the centre.

Safeguarding of residents from all forms of abuse was largely promoted and in response to recent peer to peer related incidents, the provider put in place additional staff support in place to reduce the likelihood of similar incidents from re-occurring. Staff spoke with inspectors about the safeguarding concerns that were in place at the time of this inspection and were very aware of their role and responsibilities in implementing the recommendations set out in safeguarding plans.

Regulation 13: General welfare and development

The provider had ensured each resident was provided with care and support in accordance with their assessed needs and wishes. Residents were also supported to access facilities for occupation and recreation in line with their capacities and interests.

Judgment: Compliant

Regulation 17: Premises

The centre comprised of five apartments that provided residents with their own bedroom, some en-suite facilities, bathrooms, kitchen and living area. A communal courtyard was available on the premises, for residents to use as they wished. Although each apartment was decorated to the preference of each resident, the inspectors observed that general maintenance and re-decoration works were required to some areas of these apartments.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Although the provider had good systems in place for the identification and response to risk in this centre, improvement was required to the overall assessment of risk to ensure risk assessments gave clear hazard identification, better clarity on the

controls put in place in response to these risks and accurate rating of risk. Furthermore, although many organisational related risks were being actively managed, some did not have a supporting risk assessment in place to allow for the overall effectiveness of control measures to be subject to continued monitoring.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Since the introduction of public health safety guidelines, the provider put a number of measures in place to protect the welfare and safety of all residents and staff. Regular temperature checking, social distancing, hand washing and use of PPE were routinely practiced. Contingency plans were also in place, should an outbreak of infection occur at this centre.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had fire safety precautions in place, including fire detection and containment arrangements, emergency lighting and fire safety checks. Although there was a fire procedure in place, it required additional review to ensure it accurately guided staff on what to do in the event of fire.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The provider had procedures in place for the safe prescribing, administration and storage of medicines. Some residents were supported to take responsibility for the administration of their medicines and safe measures were put in place for residents to do so, in accordance with the outcome of a capacity risk assessment.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The provider had systems in place to ensure residents' needs were re-assessed on a

minimum annual basis.

Judgment: Compliant

Regulation 6: Health care

Where residents had health care needs, the provider had ensured that these residents received the care and support they received. Many residents were independent with their health care needs and staff were aware of their role in supporting these residents with this, as and when required.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where residents had behaviour support needs, the provider had ensured that adequate arrangements were in place to support these residents. Although behaviour support plans were in place for these residents, some required additional review to ensure these gave clarity to staff on how to respond to specific behaviours, in accordance with recent behaviour related incidents which had occurred. Where restrictive practices were in place, suitable arrangements were in place for regular multi-disciplinary review, ensuring the least restrictive practice was at all times used.

Judgment: Substantially compliant

Regulation 8: Protection

In response to safeguarding concerns, the provider had put in place additional arrangements to ensure each resident was protected from abuse. These arrangements were also clearly described within safeguarding plans, which were readily available to staff.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights were very much promoted in this centre, with many residents

leading the lifestyles that they wanted. Staff were very respectful of each resident's individual wishes, right to privacy and preferences and much effort was made to ensure residents were encouraged to make choices about how they wished to spend their time.
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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	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 Logan House OSV-0003468

Inspection ID: MON-0032875

Date of inspection: 09/11/2021

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

This document is divided into two sections:

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

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

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

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

Section 1

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

Compliance plan provider's response:

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: • Recently completed Annual review to include resident's views – all residents / families /representatives to be offered the opportunity to meet with the ISM as part of the annual review and their feedback to be included in the annual review. This will be completed 28/02/2022. • Six monthly audit process is currently being updated revised format will include a review of maintenance and premises relates issues. This will be completed by 31/01/2022.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • Painting to be carried out on entrance hall and stairwell of main building. This will be completed by 31.03.22 • Flooring to be replaced in apartment 1, entrance area and staff office by 31.03.22 • Replacement of furniture in apartment 1, 2 and 5 by 28/02/22. • Declutter of bedroom in Apartment 5 was completed 03/12/21. - • Apartment 5 bedroom flooring to be replaced – 31.03.22	

• Apartment 5 Bathroom/ensuite - shower chair to be replaced by 31/12/21.

• Apartment 5 sanitary ware to be reviewed by the landlord be replaced where required – this will be completed by 31.03.22. dependent upon securing competent contractors.

• Maintenance to be completed on self-closing fire doors, work commenced on the 03/12/21 to be completed by the 31/01/22.

• Magnet lock has been repaired in apartment 3 kitchen door entrance, this was completed on 03/12/21.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• PIC completed risk management workshop with Health & Safety Team on 01/12/21.

• PIC to complete a review of risks identified in the service to identify gaps and complete any required risk assessment by 31/12/21.

• PIC to complete review of existing risk assessments to ensure they include clear hazard identification, controls and risk rating, this will be completed by 28/02/22.

• Review newly identified risks at team meetings to allow for discussion with the team to develop proactive and robust risk management within the service, this will be completed by 11/12/21.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• PIC to review Fire evacuation procedure to include the detail that already contained within the service business continuity plan to clearly guide staff on what to do in the event of fire. Currently under review to be circulated and discussed at next team meeting by 11/12/21.

• Complete fire drill with residents, when the service is at full capacity with minimal levels of staff by 31/12/21.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

• Behavior Therapist has regular input and oversight of resident's behavior support plans. Additional review of one resident's Behavior Support Plan commenced on the 03/12/21, full review of Behavior Support Plan to be completed by 31/01/22.

• Draft Behavior Support Plan for another Resident to be finalised following assessment of behavior with resident. To be completed by 28/02/22.

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 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/03/2022
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	28/02/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a	Substantially Compliant	Yellow	28/02/2022

	system for responding to emergencies.			
Regulation 28(5)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place and/or are readily available as appropriate in the designated centre.	Substantially Compliant	Yellow	31/12/2021
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	28/02/2022