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:	Cork City North 15
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	25 May 2022
Centre ID:	OSV-0005395
Fieldwork ID:	MON-0037009

About the designated centre

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

Cork City North 15 is comprised of 3 purpose-built bungalows which are located within a secure campus setting adjacent to another designated centre and a day activation centre on the outskirts of cork city. The designated centre can provide full residential care for up to 17 adult residents. Two bungalows are comprised of six individual bedrooms, kitchen, dining and sitting room, music room, laundry and linen room. Each bungalow also has two shared bathrooms and an additional toilet for residents to use. There is a connecting corridor between two bungalows where a staff office and facilities are located. The third bungalow has been restructured to create one self-contained apartment styled dwelling to support one resident and the rest of the bungalow can support a maximum of four residents. The centre supports residents with mild, moderate and severe/profound levels of intellectual disability with many residents presenting with additional complex needs and behaviours that challenge. Residents are supported by a staff team that comprises of both nursing and social care staff by day and night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	14

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
Wednesday 25 May 2022	09:10hrs to 17:00hrs	Elaine McKeown	Lead

What residents told us and what inspectors observed

This was an unannounced focused inspection which was scheduled to assess if infection prevention and control, (IPC) practices and procedures within this designated centre were consistent with relevant national standards. However, findings during the inspection prevented the completion of the IPC inspection. The inspector issued an urgent action to the provider and completed a risk inspection on the day.

The inspector visited each house in this designated centre at times during the day that fitted in with residents routines. Most of the residents in this designated centre required ongoing staff support with activities of daily living, (ADLs). The inspector met nine of the residents during the day. On arrival at the designated centre one resident was busy completing their household chores which included collecting the daily milk required for their house. The resident was wearing a face mask at the time and was observed to complete their hand hygiene before leaving the area. The resident informed the inspector that they were happy to be busy and meeting people and staff around the day centre.

On arrival at the first house with the CNM2, a staff member unlocked the entrance door. The inspector was introduced to staff members and there were two residents in the communal sitting room watching television. At the time of visiting there were two dedicated cleaning staff completing scheduled daily cleaning activities. These staff outlined their roles and responsibilities to the inspector within the designated centre. The inspector completed a walk around of the house and observed a number of maintenance issues which adversely impacted effective IPC measures being completed which will be further discussed in the quality and safety section of this report.

On visiting the second house, the inspector was introduced to another two residents who were in the large communal sitting room. One was resting on a couch and the other was watching a preferred programme on television. Both residents were observed to engage with the staff who were familiar to them. Staff outlined how the residents were supported to go out for walks or spins in the locality with staff regularly. While the inspector was in the dining room another resident was observed to be supported by a staff member to sit down in their preferred chair to have their breakfast. The resident smiled at staff as they prepared to have their meal. Staff explained that the residents in this house preferred when there were less people in the building, the inspector did not wish to cause any anxiety for residents and left the house.

Just before lunch time, the inspector was informed that the residents in the third house were after completing their morning routine and the inspector could visit the house. This house had been sub-divided into an apartment dwelling for one resident and supported another resident in the main house. The inspector only met the resident living in the apartment as the other resident was resting in their room as

per their daily routine. The resident acknowledged the inspector when introduced by staff. The staff team outlined how the renovated apartment and personal space had improved the resident's quality of life. They were able to manage their daily routine without being impacted by other residents. This included having choice to spend time alone in a safe environment, choosing what time they started their day and engaging with staff while making personal choices around their clothes, activities and meals. Staff had taken photographs of activities that the resident was regularly enjoying such as visiting garden centres, cafes and other community settings.

While completing a walk around of the third house, the inspector noted a fire door missing from a room that was on the main hallway and an opening into an attic space above an extractor fan in the apartment kitchen. These issues will be further discussed in the quality and safety section of this report.

The staff team were observed to demonstrate good hand hygiene practices throughout the inspection. In addition, the team had supported residents who had contracted COVID-19, during outbreaks in January 2021 and February 2022. Staff outlined to the inspector how the team had effectively supported two residents in one of the houses not to contract the illness when a number of their peers were unwell in the most recent outbreak.

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

Capacity and capability

The overall governance and management in place, in particular in terms of monitoring being carried out required further review to ensure that there was consistent and effective oversight regarding fire precautions, risk assessment, infection prevention and control practices followed in this designated centre.

The person in charge was not available on the day of the inspection. The clinical nurse managers CNM2 & CNM1, provided the inspector with all requested documentation and information during the inspection. They were familiar with the assessed needs of the residents and aware of their roles and responsibilities in the designated centre.

The inspector was informed that the provider was actively recruiting staff and at the time of the inspection there were a number of vacancies. However, a new staff member was due to commence work in a full time position in the days following this inspection. The core staff team supported residents in each house with regular relief staff also available to support the residents in their homes. In addition, there were dedicated activation staff assigned to the designated centre who also provided support to residents either in their homes or in the near by activation centre. The

inspector was informed that at least one familiar staff was rostered in each house at all times to ensure residents individual preferences and routines were consistently maintained. This had assisted in reducing the anxiety experienced by some residents. In addition, changes made to the layout and design of one of the houses had a positive impact for the residents living in that house. Another resident had been supported to move to a community house as per their wishes during 2021. However, after a period of a number of months the resident requested to return to the designated centre. This was supported by the provider and staff team. The resident moved into another house in the designated centre and staff outlined how this was working well for the resident. The inspector was informed that only one nurse was on duty in the designated centre at night time. The statement of purpose stated that 1.5 whole time equivalent nurses worked in the designated centre at night. The actual and planned rota had one nurse on duty at night time with additional care staff supporting the residents in each of the three houses. The statement of purpose did not accurately reflect the actual rota for staffing levels at night time.

The inspector reviewed the complaints log for the designated centre. The person in charge had identified gaps in the staffing roster once they arrived on duty on 16 August 2021. They followed the provider's procedures and escalated the issue to senior management. The staff on duty continued to support the residents, one of whom experienced increased anxiety during the day. The impact of this increased anxiety was documented by the person in charge. The complaint was made after the person in charge and staff team had not received any response throughout the day from senior management. The person in charge was concerned about the lack of communication from senior management. A meeting with the person in charge and allocations officer was scheduled on 25 August 2021. The person in charge submitted a further escalated risk on 14 September 2021 relating to the complaint and safe staffing levels following a change of governance in the designated centre. The regional manager accepted the risk at that time and the issued was resolved to the satisfaction of the complainant on 22 November 2021.

Following a walk around of the third house and identification of risks relating to fire safety the provider was informed that the inspection was changing to a risk inspection. The risks identified by the inspector included the absence of a fire door from the music room. This had occurred on 3 May 2022 and a replacement door was ordered. However, no risk assessment or actions to reduce the risk of fire had been completed at the time of the inspection. In addition, no staff were aware of an opening directly into the attic space over an extractor fan in the renovated apartment. These issues will be further discussed in the capacity and capability section of the report.

Following a review of documentation, the inspector noted that the person in charge had repeatedly contacted the facilities department over a number of months seeking maintenance issues to be addressed. Some of the issues related to identified works that remained outstanding since the completion of the renovation works in the apartment in January 2021. These issues included the installation of an external fire assembly point sign for the resident residing in the apartment. This remained incomplete at the time of this inspection. In addition, the person in charge clearly

outlined in their monthly correspondence between September and November 2021, the time lines that each issue had remained unresolved. There was one issue identified in August 2020 relating to a bathroom in one of the houses. The required items which had been purchased were in storage with the issue remaining unresolved. The facilities manager completed a walk around with the person in charge in December 2021. However, some issues submitted through the provider's maintenance management system remained unresolved for prolonged periods at the time of this inspection. The inspector noted that the provider's annual review of the designated centre in May 2021 found regulation 17: premises compliant with reference to maintenance requests being managed through the provider's maintenance system.

Regulation 23: Governance and management

The provider had not ensured that effective management systems were place to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. In addition, the provider had not demonstrated effective arrangements were in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose did not accurately reflect the staffing at night time in the designated centre.

Judgment: Substantially compliant

Quality and safety

The inspection had commenced as a focused infection prevention and control inspection. While there was evidence that infection prevention and control practices were part of the routine delivery of care and support to residents, improvement was required to ensure these were carried out in a consistent and effective manner. A number of issues had been identified during the walk about-:

- Broken hand sanitiser units and hand towel dispensers.

- Discarded clothing which had previously been worn was observed on the floor of a shower area.
- Water damage and egress into wooden structures was observed in a number of areas throughout the designated centre, this included skirting boards with evident damage in a hallway and mould evident on a wooden box at floor level in a staff bathroom.
- Damage evident to surfaces on dining tables and chairs which reduced the ability for staff to effectively clean the areas.
- A build-up of food debris was evident on work surfaces where the kitchen hatches were located.
- An extractor cooker hood had evidence of grease build–up.
- The base and door of one of the cookers in the designated centre had evidence of food deposit build-up.
- Damaged surfaces to kitchen presses and floor surfaces.
- No checks were being completed/documented to reduce the risk of Legionella disease in water outlets that were not being regularly used. However, a number of completed audits in the designated centre under the provider's No 1 "Work safely protocol", one of which was not dated or signed, had repeatedly marked that checks were in place.
- Damaged surface areas in one bathroom, impacted the effective cleaning of the area and prolonged water egress was evident out into the hallway.
- The recording of the completion of daily cleaning of frequently touched points did not clearly outline when the actions were being done. For example, one house recorded the wording "quarterly" on the daily entries.
- The protocols in place to check staff temperatures at the commencement and during each shift required further review. Not all dates had staff temperatures documented. For example, on the day of the inspection at 11:30 hours no entries for the staff in one house had been documented due to the competing needs of the residents at the start of the shift. No recordings were documented for any staff in the same house on either the 2 or 3 February 2022.
- Some waste bins were observed to be broken with no lids.
- The designated centre did not have any spill kits.
- Not all staff were aware that there was a requirement for Filtering Face piece, (FFP2) masks to be worn when supporting residents as per the public health guidelines that were effective at the time of this inspection.

The inspector acknowledges that the staff team had effectively supported some residents to remain safe and free from infection during an outbreak of COVID-19 in January 2021 and during another outbreak in one of the houses in February 2022. All of the residents and staff affected during these outbreaks had recovered. The dedicated cleaning staff outlined the different cleaning products and dilution ratios in use in the designated centre to the inspector. The provider had two staff identified as COVID-19 leads in the designated centre. There had been monthly IPC committee meetings and an IPC auditing schedule. These audits included decontamination, environmental and hand hygiene audits. The provider had also committed to providing training for a number of staff to become hand hygiene auditors. Staff from this designated centre were scheduled to attend this training in

July 2022. The person in charge has also regularly reviewed the Health Information and Quality Authority Self-assessment in preparedness planning and infection prevention control assurance. The most recent review was completed on 18 January 2022. The provider had reviewed the requirement for the derogation of staff but had been able to redeploy staff from other areas and did not need to implement derogation for any staff member in this designated centre.

Additional issues were identified by the inspector when the inspection was changed to a risk inspection in the afternoon. The centre's risk register had been subject to regular review. The most recent review completed in December 2021. However, not all centre specific risks had been identified and assessed at the time of the inspection. In addition, the individual risk assessments for some residents had not been reviewed by the documented review date. For example, the risk relating to one resident going swimming was reviewed in May 2021 and due to be reviewed again in November 2021, but no review had taken place by the time of this inspection.

The inspector reviewed the personal files of three residents and found not all follow up reviews by the multi-disciplinary team, (MDT) and allied healthcare professionals had been completed within the required time frames. One resident had not had an annual review completed since February 2021. A referral for the same resident in relation to their effective communication was sent to the speech and language therapy department in 2018. The person in charge had submitted annual emails to the department seeking the referral to be completed. The most recent email was sent in March 2022. The resident was also under the care of dietician services. Recommendations had been made in March 2022. However, the monthly monitoring of the resident's weight and body mass index was not being documented consistently in recording charts contained in the resident's personal plan. A review of a resident's mental health had not occurred six monthly and a healthcare plan had last been reviewed in May 2021 and was documented to be reviewed again in six months.

There were a number of issues identified relating to fire precautions. Two of these required an urgent action to be issued by the inspector on the day of the inspection. The provider ensured the open section of ceiling into the attic space above an extractor fan in the apartment was rectified before the end of the inspection. The inspector returned to the kitchen to see a vent in place and the housing unit of the extractor fan fitted up to the ceiling.

The provider was requested to submit details of actions taken to ensure the safety of the residents living in the house which did not have an internal door in place in the music room. The provider submitted details of the actions taken and controls in place to ensure the safety of the residents while the replacement door was not in place. This was submitted to HIQA as requested by 31 May 2022.

While reviewing the fire safety checks that had been documented for the house, the inspector noted that a weekly check of automatic fire doors on 14 May 2022, had "no actions". However, the music room door was not in place since the 3 May 2022. The documenting of daily checks was also not consistent. No entries were documented for 6 May 2022, other dates had two entries, one per shift as per the

provider's protocol. However, some dates only had one entry documented for example the 11 and 12 May 2022. This is during the period when the internal fire door was not in place in the music room. The inspector also noted on one resident's personal emergency egress plan, (PEEP) had been reviewed on two occasions since they moved into their new apartment. The reviews had taken place in March 2021 and February 2022. At the time of the inspection the PEEP still identified that the external fire assembly point was awaited and the resident was required to walk a greater distance to another assembly point during fire drills.

Regulation 17: Premises

The provider had not ensured the premises was kept in a good state of repair.

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider had not ensured all risks in the designated centre had been identified at the time of this inspection. Effective systems to ensure on the ongoing assessment, management and review of risks in the designated centre were required to be consistently in place.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had not ensured that residents who may be at risk of a healthcare associated disease were consistently protected. Improvement was required to ensure that infection prevention and control practices were carried out in a consistent, effective manner and in line with public health guidance.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had not ensured that effective fire safety management systems were in place, which included effective fire containment measures.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Not all residents had comprehensive assessments completed annually, regular reviews by allied healthcare professionals had not always taken place within the time frame documented and referrals remained outstanding for other residents.

Judgment: Substantially compliant

Regulation 6: Health care

Not all residents healthcare plans had been reviewed within the documented time frames in their personal plans.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Substantially compliant

Compliance Plan for Cork City North 15 OSV-0005395

Inspection ID: MON-0037009

Date of inspection: 25/05/2022

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Staff meeting held 10/06/2022 to discuss government and management systems and relevant reporting mechanism • Governance walk around to be completed weekly and documented appropriately. • The PPIM will contact the organisational Quality Team in relation to regulation 23.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: Statement of purpose has been reviewed and updated to reflect the staffing numbers by night	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • Full facilities walkaround completed with facilities manager and PIC 15/06/2022 • Hand sanitizer units and hand towel dispensers have been ordered	

• Quotations sent to accounts for replacement pedal bins
• Flooring has been reviewed and sanctioned.
• Staff Bathroom reviewed by facilities manager, materials ordered and work to commence once materials received
• New Cooker has been ordered for one house in the area of concern
• Bathroom of concern has been reviewed by facilities manger 15/06/2022. Works have been sanctioned and materials have been ordered. Awaiting same.
• Replacement kitchen tables have been ordered through internal maintenance system
• Painting has been sanctioned
• Protocol has been created for staff to report outstanding maintenance issues to management
• Deep Clean of service hatches in use has been requested. Removal of service hatches not in use has been sanctioned.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• Risks reviewed with additional controls added to reflect the absence of a fire door
• All individual risks in designated center have been reviewed and updated
• Annual review of risks scheduled.
• Risk assessment reviewed and updated to reflect changes with fire and infection control.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• Hand sanitizer units and hand towel dispensers have been ordered
• Quotations sent to accounts for replacement pedal bins
• Facilities walkaround completed 15/06/2022 with facilities manager and PIC. Flooring has been reviewed and sanctioned.
• Documentation updated to reflect daily temperature checks
• Staff Bathroom reviewed by facilities manager, materials ordered and work to commence once materials received
• Extractor fans cleaned. Quotations have been received for deep cleaning of all kitchens.
• New Cooker has been ordered for one house in the area of concern

• Spill Kits now on- site. • Bathroom of concern has been reviewed by facilities manger 15/06/2022. Works have been sanctioned and materials have been ordered. Awaiting same. • Staff are now compliant with mask wearing in accordance with HSE guidelines.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: • New recordings for issues in relation to fire safety has been developed, to ensure that any safety issues are reported to the relevant contractors immediately. Management continue to do weekly walkthrough of houses to review any maintenance, health and safety issues. • Protocol in place for guidance for staff to report maintenance issues that arise • All staff working in house 3 have completed fire awareness training with CNM1 and CNM2 in relation to notification of any fire safety issues this includes any issues in relation to doors, equipment, lights and alarms. Fire awareness training to include new assembly points and risk assessments updated (26-5-2022), all remaining houses will receive the training by 23/06/2022 • Staff meeting held 10/06/2022 to update staff on relevant changes made to reflect fire safety and the importance of completing daily fire checks. • Risks reviewed with additional controls added to reflect the absence of a fire door • Fire door was re-installed 10/06/2022 and risk reduced to reflect same • Fire assembly is in lace for the purpose-built apartment.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: • Annual MDT review was completed in March 2022 for all residents in designated center. Paperwork has now been received • All referrals have been actioned accordingly

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care: • Health management plans under review by nursing team.	

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.	Not Compliant	Orange	31/08/2022
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	Red	31/05/2022
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to	Not Compliant	Red	31/05/2022

	raise concerns about the quality and safety of the care and support provided to residents.			
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 system for responding to emergencies.	Substantially Compliant	Yellow	31/05/2022
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	31/08/2022
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Red	10/06/2022
Regulation 28(3)(a)	The registered provider shall	Not Compliant	Red	31/05/2022

	make adequate arrangements for detecting, containing and extinguishing fires.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	27/05/2022
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	10/06/2022
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Substantially Compliant	Yellow	22/07/2022