Office of the Chief Inspector

Report of an inspection of a Designated Centre for Older People

<table>
<thead>
<tr>
<th>Name of designated centre:</th>
<th>TLC Carton</th>
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</thead>
<tbody>
<tr>
<td>Name of provider:</td>
<td>TLC Spectrum Limited</td>
</tr>
<tr>
<td>Address of centre:</td>
<td>Tonlegee Road, Raheny, Dublin 5</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>27 March 2019</td>
</tr>
<tr>
<td>Centre ID:</td>
<td>OSV-0005800</td>
</tr>
<tr>
<td>Fieldwork ID:</td>
<td>MON-0025411</td>
</tr>
</tbody>
</table>
About the designated centre

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

TLC Carton is a purpose-built nursing home designed to meet the individual needs of the older person, whilst facilitating freedom and independence for the more active. TLC Carton is located off the Malahide Road and close to Beaumont Hospital, and can accommodate male and female residents (over 18 years of age) up to a maximum of 163 residents.

The building has three floors consisting of 135 single bedrooms and 14 of double/twin bedrooms. Each bedroom has a full en-suite and furniture which includes a television, call bells and a phone. Each floor is serviced by stairwells and passenger lifts and access to outdoors spaces are available on the ground and first floor.

TLC Carton provides long term, respite care and stepdown care to meet the health and social needs of people with low, medium, high and maximum dependencies. The centre provides 24 hour nursing care. The provider's aim is to ensure freedom of choice, promote dignity and respect within a safe, friendly and homely environment that respects the individuality of each resident who chooses to reside in TLC Carton. A commitment to promoting the independence of residents, personally, medically, psychologically, socially, spiritually, active and fulfilling a life is set out as the objectives within the centre's statement of purpose.

Residents and families will be encouraged and supported at all times to participate in decision making regarding care, where appropriate, and residents will be supported to develop new friendships and participate in activities appropriate to their needs.

The following information outlines some additional data on this centre.

<table>
<thead>
<tr>
<th>Current registration end date:</th>
<th>02/12/2021</th>
</tr>
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<tbody>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>52</td>
</tr>
</tbody>
</table>
How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (hereafter referred to as inspectors) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

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

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

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.
This inspection was carried out during the following times:

<table>
<thead>
<tr>
<th>Date</th>
<th>Times of Inspection</th>
<th>Inspector</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>27 March 2019</td>
<td>10:00hrs to 17:30hrs</td>
<td>Sonia McCague</td>
<td>Lead</td>
</tr>
</tbody>
</table>
**Views of people who use the service**

Residents were complementary and positive with regard to their facilities, bedrooms, care and medical services, laundry and return of clothes, the control they had in their daily lives, activities and the choices they could make.

Residents said their daily routines, activity provision and plans, and interactions with the local and wider community was excellent. Many compared the facility and service to a 5 star hotel.

All of the residents were complimentary of the staff team and expressed great satisfaction regarding food presentation and mealtimes, and of their ability to have a snack at any time. Relatives spoken with were equally complimentary and told the inspector they were offered opportunities to dine with their spouse when visiting at mealtimes and as family members were offered hot drinks or refreshments when visiting.

Both residents and relatives were happy with the service and described staff as kind, responsive and caring.

Residents felt safe and were able to identify whom they would speak with if they were unhappy with something.

Many of the residents spoken with commented positively on their large and beautifully manicured garden, ornate statues and large gazebo for smokers.

Overall, conversations with residents, relatives and visitors during the inspection were positive in respect to their view of the provision of the care, facilities and services provided.

**Capacity and capability**

This is a new centre that was registered to operate as a designated centre in December 2018.

Good leadership, governance and management arrangements and effective systems were in place which contributed to residents experiencing a good service and fulfilling quality of life. Consultation forums for residents was established.

Auditing systems and management oversight arrangements were in place to capture statistical information in relation to operational matters, resident outcomes,
dependency and occupancy, recruitment and staffing arrangements. A risk register was established that was subject to regular reviews. Policies required under schedule 5 were available to guide practice and newly recruited staff.

Minutes of monthly governance and operational meetings held were available to confirm the governance and oversight arrangements described that involved senior managers and heads of departments meeting to discuss operational matters, developments, key performance indicators and resident outcomes.

Staff confirmed that they had adequate resources, supervision and direction from management, and had time to carry out their duties and responsibilities. The management team explained and demonstrated systems were in place to recruit, induct, supervise and appraise staff.

Recruitment procedures were in place and samples of staff files reviewed against the requirements of schedule 2 records were found to be compliant. The provider representative and person in charge told the inspector that all staff had completed Garda vetting prior to their commencement on duty.

Staff training and development was promoted and an ongoing training programme was described with dates agreed for the coming weeks. The training and development policy included mandatory training required in health and safety, manual handling, cardio pulmonary resuscitation (CPR), fire safety and safeguarding. However, the training tracker record maintained did not include all of these topics and it did not include all rostered staff. A review of the training and development policy was required to ensure training relevant and specific to each discipline and each staff members role and responsibilities was clearly included and approved by management.

Staff on the day of the inspection were seen to be sufficiently supervised and were supportive of residents and responsive to their needs in a timely manner. Staff handovers, allocation and meetings formed part of the operational management and communication systems that afforded staff to report and raise issues with management, problem solve and discuss areas to be developed, improved or escalated.

Records required under Schedule 3 and 4 stored securely and available on request. A record of visitors, contracts of service provision, staff rosters and insurance cover was maintained.

The registration certificate, fire safety procedures and complaints procedure was available and seen on display in the reception area to inform residents and visitors.

Complaints and feedback from residents and their relatives were listened to, taken seriously and acted upon in a timely way. The centre had a copy of the complaints procedure on display in the centre, it was clear and easy to understand.

Residents and relatives who spoke with the inspector were clear of their rights and knew the procedure to follow should they wish to complain. A member from a
national advocacy service had attended a residents committee meeting to inform residents of the role and availability of this service. Information for the contact details of the advocacy service were displayed.

**Regulation 14: Persons in charge**

The person in charge was qualified and skilled for her role and responsibilities. She demonstrated good leadership qualities and a good understanding of the regulations and standards pertaining to the care and welfare of residents in the centre.

She has developed and maintained effective management systems to manage the day to day operation of the centre, and to audit and promote continuous improvement.

The person in charge is supported by the provider representative, a clinical management team and heads of departments for the TLC group who meet formally on a monthly basis and as needed.

Residents, relatives and staff were familiar with the governance and management team and were complimentary of them.

**Judgment:** Compliant

**Regulation 15: Staffing**

Staffing levels and the staff skill mix at the time of inspection were sufficient to meet the health and social care needs of the existing residents (52). Plans to increase staff numbers and skill mix as resident numbers increase was confirmed.

Staff reported sufficient time, support and resources to carry out their duties. Residents reported they were sufficiently supported and assisted by staff when required. Relatives spoken with concurred.

**Judgment:** Compliant

**Regulation 16: Training and staff development**

While the person in charge and the senior management team were instrumental in identifying, sustaining and developing staff knowledge, competencies and skill sets by supervision and development in practice and the provision of relevant training, some gaps in relevant and mandatory staff training were identified. Training to
address the gaps was planned for the following week.

Judgment: Not compliant

**Regulation 21: Records**

Records listed in Schedules 2, 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People), Regulations 2013 (as amended) were available. The sample of records reviewed by the inspector were compliant.

Judgment: Compliant

**Regulation 22: Insurance**

The centre's insurance cover was current in the record available.

Judgment: Compliant

**Regulation 23: Governance and management**

There was a clearly defined management structure in place with explicit lines of authority and accountability, as outlined within the statement of purpose.

Systems and monitoring arrangements were established and in place to manage and govern this centre. There were sufficient resources in place to ensure the effective delivery of care although closer monitoring and assurance measures regarding staff training was required as outlined under regulation 16.

The provider representative, person in charge, management and staff team responsible for the governance, operational management and administration of services and resources participated in this inspection and demonstrated sufficient knowledge and ability to meet regulatory requirements.

An annual quality review template and plan to implement this was available to audit the service, identify trends and ensure that quality care is delivered in accordance with all relevant standards.

Judgment: Compliant
**Regulation 24: Contract for the provision of services**

A contract of care and for the provision of services outlining the terms and conditions of each residents stay were completed following admission.

Judgment: Compliant

**Regulation 3: Statement of purpose**

The statement of purpose and function was available in the centre.

It detailed the aims, objectives and ethos of the centre, outlined the facilities and services provided for residents and contained information in relation to the matters listed in schedule 1 of the Regulations.

The provider representative and person in charge understood that it was necessary to keep the document under review and notify the Chief Inspector in writing before changes could be made which would affect the purpose and function of the centre since it’s registration.

Judgment: Compliant

**Regulation 31: Notification of incidents**

Notifications of incidents and events were submitted to the Office of the Chief Inspector, as required.

Judgment: Compliant

**Regulation 34: Complaints procedure**

There was an effective policy in place to manage complaints or concerns received by staff in the centre. The person in charge was the named person to manage complaints in the centre. An independent appeals process and availability to contact external agencies such as The office of the ombudsman was also included in the policy.

Residents who spoke with the Inspector were clear of their rights and knew the
procedure to follow should they wish to complain. as did relatives.

Judgment: Compliant

**Regulation 4: Written policies and procedures**

Policies and procedures required under Schedule 5 were available. From the sample reviewed the Inspector noted that all policies had not been approved or recorded as read by staff, as required.

Additionally, the staff training and development policy required review and improvement to ensure it addressed the training and development to be provided and completed by all staff within each discipline, and the frequency for refresher training provision.

Judgment: Substantially compliant

**Quality and safety**

Arrangements for residents to be consulted with and participate in the organisation of the centre on a day-to-day basis were described and set up. A residents committee was established and a meeting was advertised to take place the following day.

Staff were allocated to care and support residents on a daily basis. Staff knew residents and their relatives well, and residents were familiar with the management and staff team.

Arrangements were in place to promote residents' privacy and dignity, and many residents were supported and facilitated to make choices and to be independent and active. There were opportunities for residents to participate in group or individual activities that suited their interests and abilities. An activity programmes was in place and being developed on a weekly basis in order to tailor it to meet the likes and preferences of existing and new residents. Dedicated activity staff were available. The inspector was told by activity staff that a group of residents had attended an outing last week with them to a local bowling arena. The group enjoyed this outing which would now feature in the regular activities. A garden party was in being planed for this weekend and a variety of occupation, exercises and meaningful activity opportunities were available daily.

Residents had timely access to a general practitioner (GP), a pharmacy service, to an allied healthcare and community care professionals. A drugs and therapeutic committee in the centre was established. This committee included the provider
representative, person in charge, persons participating in management, the general Practitioner (GP) and pharmacist who had met last on 22 February 2019 to discuss medication management and services available for residents of the centre.

There were processes in place to ensure that when residents were admitted, transferred or discharged to and from the centre, relevant and appropriate information about their care and treatment was available and maintained, and shared between providers and services.

Arrangements were in place for the assessment, care planning and evaluation process. Residents who had been admitted with pressure ulcers and those who had developed low grade ulcers had been referred to a tissue viability nurse/specialist who had assessed and provided recommendations for their treatments plans that had promoted healing. Pressure relieving devices and relevant equipment and resources were also made available. Ongoing assessments and care plan reviews were maintained to promote further healing and prevent deterioration.

Interventions recommended by and engagement with allied healthcare professionals such as a physiotherapist and occupational therapist in relation to the prevention and management of pressure ulcer and falls had were reflected in specific care plans and overall prevention strategies. An audit of falls was completed to identify trends and put control measures in place to mitigate risks identified. Suitable equipment and aids were available to support residents needs and abilities.

The premises was suitably decorated throughout and benefited from good natural and artificial lighting. The view outdoors from rooms occupied by residents was pleasant and the decor throughout was of a very high standard.

**Regulation 11: Visits**

A register of visitors was in place and maintained at the main reception that was staffed throughout the inspection by a receptionist.

Visitors were unrestricted except during an outbreak of infection earlier this year and at protected mealtimes, if not by prior arrangement.

Residents can receive visitors in private or in a variety of communal and family rooms available on each floor.

Judgment: Compliant
Regulation 17: Premises

The location, design and layout of the centre were suitable for its stated purpose and met residents’ individual and collective needs in a comfortable manner.

The centre is registered for 163 residents and there was 52 residents accommodated on the ground and first floor at the time of the inspection. Twin bedrooms occupied were accommodating previously established couples.

This premises and environment was spacious, clean, homely and tastefully decorated and colourfully co-ordinated throughout. Furniture and fittings were of a high standard on each floor. A variety of private and open plan areas, communal and quiet rooms were available on each floor. Access to the outdoors from the ground and first floor was available.

The centre was laid out over three floors with passenger lifts and stairwells between all floors. Communal rooms were spacious, bright and fully equipped for their stated purpose. Resident bedrooms were located on each floor and each bedroom had full en-suite facilities. The total number of resident bedrooms is 149, with 135 single and 14 twin/double. The bedroom accommodation included 32 single bedrooms and three twin/double on the ground floor; 61 single and six twin/double on the first floor; and 42 single and five twin/double on the second floor.

Supportive equipment for resident such as call bells at beds, in bathrooms and rooms used by residents, furniture that included high low beds, tables, hoists, shower and wheel chairs, and pressure relieving equipment were in place. Pre-admission assessments were carried out to establish if the necessary facilities and equipment are available or to be acquired prior to each residents admission.

The decor, fittings and furnishing throughout was of a very high standard. A variety of private, family and communal rooms for residents and visitors to use was available. Laundry, Kitchen, staff facilities and training rooms within the building were located on the ground floor.

There was access to outdoors and to a spacious paved and landscaped garden available from the ground floor living area and via a balcony on the first floor. An large outdoor gazebo was available as a sheltered smoking area.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

There were processes in place to ensure that when residents were admitted, transferred or discharged to and from the centre, relevant and appropriate information about their care and treatment was available and maintained, and
shared between providers and services.

Judgment: Compliant

**Regulation 27: Infection control**

Procedures consistent with the standards for the prevention and control of healthcare associated infections were being implemented by staff.

Judgment: Compliant

**Regulation 5: Individual assessment and care plan**

Both electronic and hard copy recording systems were used for the assessment and care planning process. A selection of care plans records were reviewed. An assessment prior to a resident's admission formed part of the centre’s admission policy and practice.

A comprehensive nursing and medical assessment assessment was completed within 72 hours of admission to inform the care planning process. Social and recreational assessments and life-story plans were also completed with the involvement of residents and their family, if appropriate.

There was evidence of validated assessment tools used to monitor areas such as the risk of falls, malnutrition and skin integrity.

Judgment: Compliant

**Regulation 6: Health care**

Appropriate medical and healthcare access was available. Timely access to relevant services was described and seen recorded. Clinical governance and multidisciplinary meetings took place on a regular basis to promote and ensure appropriate healthcare for residents, and to review the effectiveness of treatment plans in consultation with residents and their representatives, if appropriate.

The quality of life for many residents in the centre was enhanced by their engagement with visitors on a regular basis and by their participation in meaningful activities such as sonas, weekly mass, games, garden access, and arts and crafts or by engagement with external entertainers and musicians. Residents expressed
The inspector was told by the person in charge and staff that the centre aimed to promote a restraint free environment in line with the national policy and that restraint was only to be used as a last resort when other alternatives had failed.

A policy reflecting national best practice guidance was available with comprehensive guidance for staff in relation to restraint usage. A restraint and enabler register was maintained and was subject to regular review and audit by the person in charge. The usage of bedrails was low and had decreased significantly for a number of residents that had used them prior to their admission.

The inspector was told by the person in charge and staff that the use of psychotropic medicines PRN (a medicine only taken as the need arises) was rarely used and not in use currently by any of the residents. Arrangements were in place so that medicines including those prescribed PRN were subject to regular reviews by nurses, a pharmacist and the resident’s general practitioner (GP).

Residents with responsive behaviour had access to a medical and outreach team within the community who were involved in their assessments and treatment plans. Liaison by the person in charge with external agencies was also described and ongoing to optimise care and enhance quality outcomes for residents with responsive behaviours as a result of an acquired injury.

Judgment: Compliant

### Regulation 8: Protection

Measures were in place and implemented to protect residents from being harmed or suffering abuse.

Judgment: Compliant
This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

<table>
<thead>
<tr>
<th>Regulation Title</th>
<th>Judgment</th>
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</thead>
<tbody>
<tr>
<td><strong>Views of people who use the service</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 14: Persons in charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 15: Staffing</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 16: Training and staff development</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 21: Records</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 22: Insurance</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 24: Contract for the provision of services</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 3: Statement of purpose</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 31: Notification of incidents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 34: Complaints procedure</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 4: Written policies and procedures</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td><strong>Capacity and capability</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 11: Visits</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 17: Premises</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 25: Temporary absence or discharge of residents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 27: Infection control</td>
<td>Compliant</td>
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<tr>
<td>Regulation 5: Individual assessment and care plan</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 6: Health care</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 7: Managing behaviour that is challenging</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 8: Protection</td>
<td>Compliant</td>
</tr>
<tr>
<td><strong>Quality and safety</strong></td>
<td></td>
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<tr>
<td><strong>Total</strong></td>
<td></td>
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</tbody>
</table>
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 Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

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. **Specific** to that regulation, **Measurable** so that they can monitor progress, **Achievable** and **Realistic**, and **Time** 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:**

<table>
<thead>
<tr>
<th>Regulation Heading</th>
<th>Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 16: Training and staff development</td>
<td>Not Compliant</td>
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</tbody>
</table>

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
- Full review of mandatory training for all staff undertaken and training tracker updated
- Mandatory training gaps analysed, and additional training dates organised to ensure full compliance of staff mandatory training
- All existing staff to be complaint with mandatory training by 31st May 2019
- Staff non-compliant with mandatory training informed of training and proposed dates for training
- CPR external training company and other TLC centre trainers accessed for mandatory sessions until TLC carton in- house trainer completes training and gains competence to be a BLS Trainer
- Annual mandatory training programme developed with scheduled sessions twice a month to ensure all new staff provided with training in timely fashion
- Training tracker will be reviewed and monitored monthly by heads of department
- 2nd manual handler trainer will be fully accessible to TLC Carton by 29th April 2019
- Onsite practice development Nurse available to assist with mandatory training provision
- Mandatory training days are paid training days to assist with staff attendance

| Regulation 4: Written policies and procedures | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
- Staff training and development policy reviewed with heads of department and now
accurately reflects specific mandatory training requirements for each department

Policy discussed at the TLC Carton management meeting chaired by CEO 10/04/19 and policy approved and signed

Policy circulated to all heads of departments and asked to communicate to all staff

All new staff are informed in their starter pack of mandatory training requirements and obligations to undertake and provide evidence of same

All schedule 5 policies approved by CEO and DON.

A list of these polices are included in the staff starter pack

Copies of the schedule 5 policies are available at each substation and reception

Staff sign a declaration that they are aware of the schedule 5 policies and where to locate them
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).

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Regulatory requirement</th>
<th>Judgment</th>
<th>Risk rating</th>
<th>Date to be complied with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 16(1)(a)</td>
<td>The person in charge shall ensure that staff have access to appropriate training.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>31/05/2019</td>
</tr>
<tr>
<td>Regulation 04(2)</td>
<td>The registered provider shall make the written policies and procedures referred to in paragraph (1) available to staff.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>03/05/2019</td>
</tr>
<tr>
<td>Regulation 04(3)</td>
<td>The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>31/05/2019</td>
</tr>
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