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

| Name of designated centre: | Bird Hill |
| Name of provider:          | St Catherine's Association Company Limited By Guarantee |
| Address of centre:         | Wicklow   |
| Type of inspection:        | Short Notice Announced |
| Date of inspection:        | 05 September 2018 |
| Centre ID:                 | OSV-0005660 |
| Fieldwork ID:              | MON-0023875 |
About the designated centre

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

Birdhill designated centre is operated by St. Catherine's Association having taken over as provider of this centre April 2018. This designated centre is a bespoke property located in a rural part of County Wicklow but within a short driving distance from local amenities and towns. The property provides residents with scenic views of the local countryside, it is modern and comfortable throughout. This designated centre is St. Catherine's Association only adult residential service. The centre has a capacity for 2 residents and provides services to persons with intellectual disabilities and autism. The centre is managed by a person in charge who also has a remit for two other designated centres which are located within a short distance from each other. A local operational manager is assigned to the centre to monitor quality and care provided in the absence of the person in charge. The centre is staffed with a whole time equivalent of 3.5 staff during the day and at night time one sleep over staff and one waking night staff.

The following information outlines some additional data on this centre.

| Number of residents on the date of inspection: | 2 |
How we inspect

To prepare for this inspection the inspector or 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>05 September 2018</td>
<td>10:30hrs to 17:30hrs</td>
<td>Ann-Marie O'Neill</td>
<td>Lead</td>
</tr>
</tbody>
</table>
Views of people who use the service

The inspector met with both residents living in the centre. One resident told the inspector, 'I do', when asked if they liked living in their new home. Another resident chose not to specifically engage with the inspector and the inspector respected the resident's wishes. Residents appeared very relaxed and content in their home. They were observed interacting with staff and it was noted staff were responsive and attentive to their needs and requests during the course of the inspection. The inspector spoke to a family member of a resident living in the centre. They were highly complementary of the service provided to their relative and told the inspector that they felt they could approach the managers and staff about any issue if one arose.

Capacity and capability

The registered provider, the person in charge and persons participating in management of the centre had effectively ensured residents were receiving a good quality service in this designated centre. Overall, the inspector found evidence of a responsive, fit provider capable of monitoring its own governance arrangements and where necessary taking responsive action to improve services provided to residents. Residents were supported by the provider to experience a good quality of life in their new home. Improvement was required in relation to Schedule 5 policies and associated procedures to ensure they were up-to-date and reflected the adult residential service provided in the centre.

The provider had appointed a person in charge for the centre. The person in charge presented as a competent and effective manager who understood their regulatory role and responsibilities to a good standard. This included knowledge of notifications required by the regulations. All incidents had been notified as required. The person in charge had maintained their continuous professional development and at the time of inspection was starting a Masters degree in management. Good levels of compliance with the regulations and standards were found on this inspection. Governance and management systems and oversight by the provider and person in charge had ensured these findings which in turn were having positive impacts for residents living in this centre.

The provider had ensured robust governance arrangements for this centre. Provisions were in place for a six monthly provider led audit to take place and also the provider had identified persons to carry out the annual review of the centre. Ongoing operational management audits were in place and there was evidence that staff were encouraged to take responsibility and be accountable, for example a
member of staff had been identified as a health and safety officer for the centre and had completed some training to perform this role.

The provider had ensured there were sufficient numbers of staff with appropriate qualifications, experience and skill mix to meet the assessed needs of residents.

The person in charge had ensured, in the main, that staff working in the centre had received required training. A training plan was in place and updated as required. Some gaps were noted in training records for staff however. The provider was required to ensure all staff working in the centre had completed training to meet the assessed needs of residents.

An effective supervision system was in place. Staff supervision meetings were ongoing and of those reviewed it was noted they were of a good quality and clearly documented; demonstrating evidence that staff used these meetings to bring forward suggestions and other matters to the person in charge for discussion and consideration.

The provider had effective governance arrangements in place to ensure the statement of purpose for the centre was regularly reviewed and met the requirements of Schedule 1 of the regulations.

Governance arrangements of the provider had ensured all required Schedule 5 policies and procedures were in place but improvement was required. Not all policies were in date and many referred to children only. Birdhill designated centre is an adult residential service. The provider was required to review, revise and update Schedule 5 policies to ensure they were up-to-date and reflected the service provided in the centre.

**Regulation 14: Persons in charge**

The person in charge met the requirements of regulation 14. They were found to be a knowledgeable and conscientious person. On review of staff supervision records and speaking with staff, they found her to be approachable and open to suggestions on how to improve the service.

**Judgment:** Compliant

**Regulation 15: Staffing**

Overall, the provider had ensured that staffing skill mix and numbers were appropriate to meet the needs of residents. A planned and actual roster was maintained in the centre which identified the name and grade of each staff.
Schedule 2 files were not reviewed on this inspection. The provider had systems in place to ensure Schedule 2 files for staff were audited to ensure compliance with the regulations.

Judgment: Compliant

**Regulation 16: Training and staff development**

Overall, the provider had ensured staff working in the centre had received the required mandatory training in relation to fire safety, safeguarding vulnerable adults, manual handling and management of behaviours that challenge. There were some gaps however, across training records reviewed.

The person in charge had begun a supervision schedule for staff working in the centre. Supervision records were maintained to a good standard.

Judgment: Substantially compliant

**Regulation 23: Governance and management**

The provider had adequate governance and management arrangements in place to meet their regulatory requirements in relation to provider led audits and an annual report for the service. At the time of inspection a number of audit assurance reviews had already been completed.

Lines of authority and accountability were clearly defined. Operational management arrangements were in place to ensure regular and consistent oversight of the quality and safety of care provision in the centre in the absence of the person in charge.

Judgment: Compliant

**Regulation 3: Statement of purpose**

The provider had produced a statement of purpose that accurately reflected the services provided in the designated centre.

Judgment: Compliant
**Regulation 31: Notification of incidents**

Incidents that required notification had been submitted to the Chief Inspector. The person in charge was aware of their regulatory responsibilities in relation to notification of incidents.

Judgment: Compliant

**Regulation 4: Written policies and procedures**

The provider had ensured all Schedule 5 policies were in place, however a number of these policies were out-of-date and many made reference to the care and welfare supports for children only. Birdhill designated centre is an adult residential service.

Judgment: Not compliant

**Quality and safety**

Overall, it was demonstrated that residents were experiencing good quality of life outcomes since moving to their new home. The provider had ensured residents were provided with a comfortable, modern home which could support residents' social care needs and integration with their local and wider community. Some improvements were required to ensure the quality and safety of care provided to residents in relation to risk management and the creation of directive support plans related to residents' assessed needs.

The provider had ensured residents were provided with a modern, bespoke home with their own bedroom and personal ensuite facilities. Residents were also afforded scenic views of the local Wicklow mountains and countryside throughout and well maintained outside spaces and a sensory room which could support their assessed sensory needs and was freely accessible to both residents at all times.

The provider had ensured residents received a comprehensive assessment of needs through an allied health professional framework. Residents' personal plans demonstrated that residents' assessed needs were reviewed regularly by allied health professionals with updated recommendations provided following each review. This ensured residents' best possible social care, physical and mental health outcomes were continuously monitored to a good standard in this centre. However, there was an overall lack of support planning in place for residents' assessed social and healthcare needs. These were required to ensure consistency in staff supports and to ensure evidence based practice was implemented in line with allied health
recommendations.

The provider had ensured safeguarding of vulnerable adults policies and procedures were in place and implemented. Details of the organisation's designated officers were available in the centre and all staff had received training in safeguarding vulnerable adults.

Residents living in this centre required positive behaviour supports to manage some personal risks and behaviours that challenge. The provider had ensured residents were supported by appropriately skilled and qualified allied health professionals. Comprehensive behaviour support planning was in place.

Residents could move freely around their home and a restraint free environment was promoted. Appropriate systems were in place for the identification and assessment of restrictive practices. Where required each restrictive practice had been evaluated for the rationale for their use and associated risks they were in place to manage. Overall, the inspector noted a relatively low level of restrictive practices were utilised in this designated centre.

The provider had ensured appropriate fire safety precautions and containment measures were in this centre and met the regulations. Fire safety equipment was serviced as required and a functioning fire alarm was present in the centre. Regular fire evacuation drills took place and it was demonstrated that residents could be evacuated from the premises in a timely way. Some improvement was required, not all staff working in the centre had participated in a fire evacuation drill.

The provider had created a risk management policy in line with their regulatory responsibilities. However, some aspects of it's implementation in the centre required improvement. A local risk register did not reflect all risks presenting and managed in the centre. Not all residents’ personal risks had been identified on the register and it was not demonstrated that a risk assessment and associated standard operating control guidelines had been drafted for the mitigation and control of risks presenting. This required improvement.

Regulation 17: Premises

The provider had ensured residents were provided a good standard of living accommodation which met all aspects of regulation 17. Residents were afforded a single bedroom each with ensuite facilities. The property also provided a sensory space and scenic views of the Wicklow countryside.

Judgment: Compliant

Regulation 26: Risk management procedures
The provider had ensured a risk management policy that met the requirements of the regulations was in place. However, improvement was required with regards to the implementation of this policy. Not all risks, including personal risks for residents, had been identified and documented in accordance with the provider's own procedures. Equally, not all personal risks for residents had a corresponding risk assessment in place with associated standard operating procedures documented to inform and guide staff in the consistent and robust management of those risks.

Judgment: Not compliant

**Regulation 28: Fire precautions**

The provider had ensured robust fire safety precautions and containment measures were in place in the centre for the most part. All fire safety equipment had received an up-to-date service with servicing records maintained in the centre. Staff working in the centre had received training in fire safety. Fire drills were carried out regularly and demonstrated effectiveness in the timely evacuation of residents.

Some improvement was required as not all staff working in the centre had participated in a fire drill.

Judgment: Substantially compliant

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

Each resident had received a comprehensive assessment of need with evidence of allied health professional assessment and recommendations prescribed and documented where required. Person centred planning goals had also been identified for residents and at the time of inspection action plans, for the achievement of these goals, were being drafted.

Improvement was required to ensure a corresponding support plan was in place for all identified assessed needs for residents. At the time of inspection it was noted there was an absence of such support planning in place to guide, inform and direct staff, which in turn would support the person in charge in their supervision of staff practice and their evaluation of the effectiveness of residents received supports.

Improvement was required in relation to the development of care plans to describe, inform and guide staff in evidence based healthcare supports for some resident's assessed healthcare needs.
<table>
<thead>
<tr>
<th>Regulation 6: Health care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents' healthcare needs were well managed and reviewed by allied health professionals as required and on a regular basis. Residents were also supported to avail of healthcare screening and attend hospital, medical and dental appointments if and when required and in a timely way.</td>
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</table>

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<tr>
<th>Regulation 7: Positive behavioural support</th>
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<tbody>
<tr>
<td>Residents had access to appropriately qualified allied health professionals. Where required comprehensive support planning was in place. All staff had received training in breakaway techniques and management of potential and actual aggression. A restraint free environment was promoted and overall a low level of restrictive practices were in use. Where restrictive practices were required a risk and rationale were identified for their use with detailed logs recorded locally within the centre.</td>
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<thead>
<tr>
<th>Regulation 8: Protection</th>
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<tbody>
<tr>
<td>All staff had received training in safeguarding vulnerable adults. An up-to-date safeguarding vulnerable adults policy and associated procedures were in place. A photograph and contact details of designated persons was displayed in the centre.</td>
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</table>
### Appendix 1 - Full list of regulations considered under each dimension

<table>
<thead>
<tr>
<th>Regulation Title</th>
<th>Judgment</th>
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<tbody>
<tr>
<td><strong>Capacity and capability</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>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 23: Governance and management</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 4: Written policies and procedures</td>
<td>Not compliant</td>
</tr>
<tr>
<td><strong>Quality and safety</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 17: Premises</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 26: Risk management procedures</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 28: Fire precautions</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 5: Individual assessment and personal plan</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 6: Health care</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 7: Positive behavioural support</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 8: Protection</td>
<td>Compliant</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 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. 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>Substantially Compliant</td>
</tr>
</tbody>
</table>

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

1. At the time of inspection, the following training deficits were acknowledged;
   a. Two staff members required First Aid
   b. One staff member required Fire Safety
   c. One staff member required Infection Control
   d. Two staff members required Intimate Care
   e. Two staff members required Manual Handling

2. As of 12th November 2018, all deficits detailed above are as follows;
   a. One staff member completed training in September 2018, the second staff member is scheduled to attend at the next available opportunity; 29th January 2019.
   b. Staff member is scheduled to attend at the next available opportunity; 16th January 2019.
   c. Staff member is scheduled to attend at the next available opportunity; 26th November 2018.
   d. One staff member completed training in September 2018, the second staff member is scheduled to attend at the next available opportunity; 26th November 2019.
   e. One staff member completed training in September 2018, the second staff member is scheduled to attend at the next available opportunity; 30th March 2019.

3. As of October 2017, St. Catherine’s Association appointed a full-time Training Development Officer whose remit encompasses all mandatory and non-mandatory training requirements for staff members employed in an SCA designated centre. As of 12th November 2018, SCA has a compliance rate of 90% for direct contact staff in Bird Hill.

4. The Person-In-Charge continually monitoring the skill mix of available staff and rostering staffing resources appropriately to ensure continuation of service is maintained.
Please be assured that specific tasks; i.e. intimate care, are not assigned to a staff member unless they have first completed the required training.

<table>
<thead>
<tr>
<th>Regulation 4: Written policies and procedures</th>
<th>Not Compliant</th>
</tr>
</thead>
</table>

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

1. The Quality, Compliance & Training Manager (QCTM) to complete a desktop review of all Schedule 5 policies by 30th November 2018.
2. A number of Schedule 5 policies are currently under review with the Senior Management Team. Policies currently being considered include:
   a. Serious Incidents and Adverse Events Policy
   b. Human Rights & Rights Review Policy
   c. Restrictive Practices Policy
   d. Intimate Care Policy
   e. Trust-in-Care Policy
   f. Visitors to Company Facilities Policy
   g. Property & Money (Children & Adults) Policy
3. The QCTM will create a priority based review schedule for all current Schedule 5 policies by 14th December 2018.
4. Workload will be delegated to the relevant policy owner / document lead and an appropriate time-scale applied for the revision process. Where multiple policy reviews are required by a single department, the review schedule will be determined by order of priority.
5. Commencing Jan 2019, two policies per month to be presented to the Senior Management Team (SMT) for consideration for approval.
6. Once approved by the SMT, revised policies to be presented to the Board of Directors (BOD) for formal approval. The BOD are due to meet, on average, every two months; meeting schedule for 2019 to be agreed by year end – 26th November 2018.
7. All Schedule 5 policies to be reviewed by 20th December 2019.
8. In line with Reg. 04(2), all new/revised policies are communicated to all staff members via the policies email account. Line Managers are responsible for adding a new/revised policy to the subsequent team meeting agenda for discussion. Finally all staff members are requested to sign a ‘Policy Sign-Off Record’ to confirm they have read and understood the new/revised policy.
9. In line with Reg. 04(3), appropriate review periods are applied to all new/revised policies. Policies are reviewed and updated in line with prescribed review dates, or sooner as required by updated legislation, national guidance, etc.
### Regulation 26: Risk management procedures
- **Not Compliant**

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

1. An assurance report, and associated documentation (risk assignments x 2 & associated operating procedures), were submitted to the Regulator on 6th September 2018 addressing the specific concerns relating to gaps in individual risk assignments identified during inspection. Corrective actions detailed in the assurance report included:
   a. All staff will be required to appropriately sign confirming they have read and understood the operating procedure in relation to resident; Complete.
   b. Revision and minor update of risk assessment has been conducted. The revised risk assessment will be highlighted to all staff through communication/message books. The revised risk assessment will be added to the agenda of the next staff meeting for further discussion; Complete.
   c. The Emergency Care Plan is available to all staff in the relevant individual’s medication folder. The care plan provides clear guidance to staff. A copy of the emergency care plan is also kept with the individual’s rescue medication at all times and accompanies the resident on all community access trips; Complete.
   d. The induction folder will be updated accordingly to provide clear directives instructing new staff in relation to relevant operating procedures, risk assessments, care plans, etc.; Complete.

2. A full scale review of current risk assessments to be undertaken by the Person-In-Charge, the Deputy Children Services Manager, the organisational Environmental, Health and Safety Officer, and other key stake-holder (as required) by 23rd November 2018.

3. Control measures will be clarified to provide clear and detailed staff directives to guide staff work practice to ensure continuity and quality of services being provided; Revised / updated risk assessments to be in place no later than 3rd December 2018.

4. The Quality, Safety and Risk Management Policy to be reviewed and updated by 18th January 2019. Review will include:
   a. Provision for the adoption a traffic light system in the identification of risk
   b. Location risk register which clearly details and defines the risk profile presented in the designated centre

5. Staff training for key stake holders and upskilling in use of the new policy to follow once policy receives formal Board approval; deadline to be confirmed.

### Regulation 28: Fire precautions
- **Substantially Compliant**

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

1. Outstanding staff member participated in a fire drill on 7th November 2018.
2. New employees to the designated centre will be scheduled to participate in a fire drill within 4 weeks of commencing employment in the designated centre; as required.

3. The Deputy Children Services Manager to monitor staff attendance/participation records for future fire drills. Deficits will be addressed directly with the relevant staff member.

<table>
<thead>
<tr>
<th>Regulation 5: Individual assessment and personal plan</th>
<th>Not Compliant</th>
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<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:</td>
<td></td>
</tr>
<tr>
<td>1. Subsequent to the designated centre’s HIQA inspection, initial discussions were held with the members of the Personal Plan Development Group on/by 14th September 2018. Staff directives, to support and guide work practice, were requested to be added to St. Catherine’s Association Personal Plan template.</td>
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<tr>
<td>2. A pilot program of the new staff directive documentation commenced in another designated centre on 10th September 2018. Revised training has been devised to support staff in completion of new documents.</td>
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<tr>
<td>3. Staff directive template was presented to the members of the Personal Plan Development Group and approved on 9th October 2018.</td>
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<tr>
<td>4. Updated training to be presented to the Personal Plan Development Group on 15th November 2018 prior to new documentation being rolled out across the organisation.</td>
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<tr>
<td>5. The Training Development Officer (TDO) will include revised Personal Plan training in the training calendar from 31st January 2019 onwards.</td>
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<tr>
<td>6. FYI - Additional deficits noted under Reg. 5 have been addressed in actions applied to Regulation 26 &amp; 28 detailed above.</td>
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</table>
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, including refresher training, as part of a continuous professional development programme.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>29/01/2019</td>
</tr>
<tr>
<td>Regulation 26(2)</td>
<td>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.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>18/01/2019</td>
</tr>
<tr>
<td>Regulation 28(3)(d)</td>
<td>The registered provider shall make adequate arrangements for evacuating, where</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>07/11/2018</td>
</tr>
</tbody>
</table>
necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.

<table>
<thead>
<tr>
<th>Regulation 04(1)</th>
<th>The registered provider shall prepare in writing and adopt and implement policies and procedures on the matters set out in Schedule 5.</th>
<th>Not Compliant</th>
<th>Orange</th>
<th>20/12/2019</th>
</tr>
</thead>
<tbody>
<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>Not Compliant</td>
<td>Orange</td>
<td>20/12/2019</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>Not Compliant</td>
<td>Orange</td>
<td>20/12/2019</td>
</tr>
<tr>
<td>Regulation 05(4)(b)</td>
<td>The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>20/03/2019</td>
</tr>
<tr>
<td>Regulation 05(4)(c)</td>
<td>The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which is developed through a person centred approach with the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident’s wishes, age and the nature of his or her disability.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>30/03/2019</td>
</tr>
</tbody>
</table>