Office of the Chief Inspector

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

<table>
<thead>
<tr>
<th>Name of designated centre:</th>
<th>Ardeen Cheshire Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of provider:</td>
<td>The Cheshire Foundation in Ireland</td>
</tr>
<tr>
<td>Address of centre:</td>
<td>Wicklow</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>16 January 2019</td>
</tr>
<tr>
<td>Centre ID:</td>
<td>OSV-0003456</td>
</tr>
<tr>
<td>Fieldwork ID:</td>
<td>MON-0023365</td>
</tr>
</tbody>
</table>
About the designated centre

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

The designated centre comprises fifteen independent bungalows and three self contained cottages located around a landscaped courtyard, together with a modern stand-alone bungalow. These homes are situated on spacious grounds near to the main building which houses offices and communal areas for residents. The fifteen self-contained bungalows each have a sitting room, kitchen, bathroom and bedroom. Two of the bungalows have two bedrooms. The three bedroom bungalow has three large en suite bedrooms and offers full time accommodation to one resident, and two rooms for respite service. There is accommodation for a maximum of 24 residents, and the provider describes the service as being offered to people who have a physical disability or neurological condition, and sometimes secondary disabilities which could include a learning disability, mental health difficulties or medical complications like diabetes. Ardeen Cheshire staff aim to support people in different areas of their lives including assistance with personal care and grooming, health support, social supports and liaising with relevant health professionals. Support offered may also include assistance with activities such as home maintenance, preparation and eating of meals, assisting with cleaning duties and grocery shopping, and the paying of bills.

The following information outlines some additional data on this centre.

<table>
<thead>
<tr>
<th>Current registration end date:</th>
<th>26/11/2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>19</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 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 - 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>16 January 2019</td>
<td>09:30hrs to 18:00hrs</td>
<td>Julie Pryce</td>
<td>Lead</td>
</tr>
<tr>
<td>16 January 2019</td>
<td>09:30hrs to 18:00hrs</td>
<td>Maureen Burns Rees</td>
<td>Support</td>
</tr>
</tbody>
</table>
Views of people who use the service

There were 19 residents on the day of the inspection, and the inspectors spoke to and spent time with 14 people.

The residents that the inspectors met had a clear understanding of verbal communication, and responded in various ways, both verbal and non verbal. Inspectors spent some time with a resident who when asked if they were happy in their home replied with a huge smile and bodily movements which indicated a positive response. Another person who could clearly indicate yes or no also responded positively.

Residents who spoke to the inspectors said that they liked their homes and the staff that supported them. People said that the staff were kind and took lovely care of them. Some people told inspectors that they were supported to make their apartments personal, and that time was spent with them to ensure that paint colours and furnishings were of their choice.

Inspectors asked two residents who share an apartment if this was their preference, and it was very clear from their response that this was a meaningful choice. Several residents told inspectors that they enjoyed their activities, some in the centre and some in the community. Residents with difficulties in communication were supported by staff, for example a staff member very clearly interpreted the comments of the inspector to a resident, who responded with understanding, and indicated positively to the question.

Capacity and capability

There were management systems in place to ensure that the service provided was safe, consistent and appropriate to the residents’ needs.

The centre was managed by a suitably qualified, skilled and experienced person in charge who had an in-depth knowledge of the needs of each of the residents. The person in charge was in a full time position and was not responsible for any other centre. He provided evidence of practice development and leadership consistent with the improvements in the care and support of residents since previous inspections.

There was a clearly defined management structure in place that identified lines of
accountability and responsibility. This meant that all staff were aware of their responsibilities and the lines of accountability.

There were robust monitoring systems and processes in place including audits, meetings, handovers and reports to the person in charge. Meetings were held regularly at both a local and a management level, and information was disseminated clearly throughout. There were weekly meetings to review any accidents and incidents including medication errors. Staff informed the inspectors that issues raised at local meetings were addressed, for example training had been provided following an issue raised at a staff meeting which had resulted in a decrease in the occurrence of a healthcare issue. Staff meetings included information sharing such as any new policies.

There was a suite of audits in place including audits of safeguarding, complaints and the system of communication. Any required actions identified through these audits were monitored by senior management via an annual audit plan. A sample of audit reports were reviewed by the inspectors and found to be meaningful and to result in improvements.

An annual review of the quality and safety of care and support had been conducted which presented a detailed analysis of service delivery including a transparent representation of the views of the residents. Six monthly unannounced visits had been undertaken on behalf of the provider as required by the regulations. Required actions were identified, and those reviewed by the inspector had been implemented. It was therefore clear that the provider had clear oversight of the care and support provided to residents.

There was a staff recruitment and selection policy in place. An actual and planned staff rota was maintained which evidenced adequate staffing levels to meet the needs of residents. Inspectors were present at two meals during the inspection and found that there were sufficient staff to meet the needs of residents, including both physical assistance and social interaction. During the course of the inspection, inspectors rang the call bell for residents, and found the response to be timely.

The staff team were found to have the appropriate skills, qualifications and experience to meet the assessed needs of the residents. The full complement of staff was in place and a significant number of the staff team had been working with the residents for a long period which provided consistency of care for the residents. All staff engaged by the inspectors demonstrated a clear understanding of the support needs of residents, both social needs and healthcare needs. Staff members were keen to engage the inspectors to discuss the needs of residents, and spoke in a caring way about residents.

Training had been provided to staff to support them in their role and to improve outcomes for the residents. There was a staff training and development policy. A training programme was in place which was coordinated by the provider’s training department. Training records showed that staff were up-to-date with mandatory training requirements.

There was a system of staff supervision which involved one-to-one discussions
throughout the management structure. Staff engaged by the inspectors said that they found the supervision supportive, and that managers and staff both had the opportunity to raise issues. However, supervision conversations were not conducted regularly, and there were some significant gaps since the last supervision for many staff. This meant that staff may not have been appropriately supported to perform their duties to the best of their abilities.

**Regulation 14: Persons in charge**

The person in charge was found to be competent, with appropriate qualifications and management experience to manage the centre and to ensure it met its stated purpose, aims and objectives.

**Judgment:** Compliant

**Regulation 15: Staffing**

The full complement of staff were in place and considered to have the required skills and competencies to meet the needs of the residents living in the centre.

**Judgment:** Compliant

**Regulation 16: Training and staff development**

Training had been provided for staff to improve outcomes for residents. Staff received supervision to support them to perform their duties, however this was not done on a regular basis.

**Judgment:** Substantially compliant

**Regulation 19: Directory of residents**

There was a directory of residents maintained in the centre which met the requirements of the regulations.
### Regulation 23: Governance and management

The governance and management systems in place were robust and promoted the delivery of a high quality and safe service.

**Judgment:** Compliant

### Regulation 24: Admissions and contract for the provision of services

Admissions to the respite service of the centre were well managed in relation to the compatibility of residents.

**Judgment:** Compliant

### Regulation 31: Notification of incidents

There were systems in place for the recording and management of all incidents. All required incidents were notified to the chief inspector as per the requirements of the regulations.

**Judgment:** Compliant

### Regulation 34: Complaints procedure

There were suitable arrangements in place for the management of complaints. A sample of complaints reviewed had been appropriately dealt with and the outcome had been recorded.

**Judgment:** Compliant

### Regulation 4: Written policies and procedures

The policies required by the regulations were in place, and a sample reviewed
by the inspectors were found to be reviewed and evidence based.

Judgment: Compliant

Quality and safety

Inspectors found that residents' well-being and quality of life was maintained by a good standard of evidence-based care and support which was person-centred and respected and promoted the rights of people living in the designated centre.

Personal plans were in place for each resident and were reviewed at regular intervals with the involvement of residents, their family representatives and the resident's multidisciplinary team. Care plans and personal support plans reflected the assessed needs of the individual residents and outlined the support required in accordance with their individual health, communication, personal and social needs and choices, thus ensuring that there was clear guidance for staff in the provision of care and support.

However, goals set in relation to maximising the potential for some residents were not specific and evidence of monitoring of progression in achieving goals set was lacking. It was therefore not clear that all residents were fully supported to achieve their potential.

The residents were each supported to engage in meaningful activities both in their homes and in the community. A weekly activity planer was on display in the main reception area. Examples of activities undertaken included bowling, cinema, archery, sensory garden, horse riding, concerts, pet farm visits, book club. Community engagement was evidenced in the participation of residents in various local activities including a Monday ladies’ club, men's shed group, dancing, theatre group, horse racing, women's networking, mindfulness sessions and 'laughing' yoga. One of the residents had a significant role in a local community group.

There was also inclusion of the local community into the daily lives of residents in the form of hosting local groups. Art work completed by a number of residents in their art class was entered in a local farm show, with a number of entries winning prices at the show. Activity participation records were maintained for each of the residents regarding activities participated in. In addition, daily social communication sheets were maintained for each individual residents’ choices for activities and community participation. There was evidence on file of regular review of community and social activities by the provider's activity coordinator in consultation with individual residents.

The centre was suitable to meet the resident's individual and social needs in a comfortable and homely way. The centre comprised a main house, bungalow apartments, a cottage and a respite unit. Two of the residents shared a two-bedroomed apartment, and inspectors found that these residents had made a clear
choice to share their accommodation. All other permanent residents had their own self contained apartment. Each resident had been supported to decorate and individualise their apartment, and inspectors were invited into some of these homes, and found residents to be comfortable in their homes, and to have appropriate supports to maintain their independence.

The main building contained a communal dining area, sitting room, activity room and offices, and residents were observed to avail of these areas in accordance with their preferences.

In addition to the permanent homes there was a separate three bedroom building assigned for respite services to a cohort of 60 people on a rotational bases, There was a resident living permanently in one of the rooms in this part of the centre, and while inspectors were initially concerned that this person had various different respite users sharing their home on a regular basis, there was clear evidence that this arrangement suited their needs. The resident had a large personal space, and was observed to enjoy the visits of other residents to their home. Staff and management had examined the practice of respite users availing of accommodation in this home, and had liaised with the family members of the permanent resident, It was evident that, rather than being intrusive, the comings and goings of respite users was adding to the quality of life for the resident.

The residents were provided with a nutritious, appetising and a varied diet. A weekly menu was agreed with residents. A healthy eating programme was promoted. All meals were provided in the main house dining room but alternatively residents could choose to have their meals in their own apartments. Some people had been facilitated to have the input from a speech and language therapist, and the recommendations were implemented.

The inspectors joined residents for a lunch time meal on the day of inspection and observed staff assisting residents in a supportive and respectful manner. Various methods of communication were observed and found to be meaningful. The meal time was a social occasion, and there were various choices on offer.

The health and safety of residents, visitors and staff was promoted and protected. There were risk management arrangements in place which included a detailed risk management policy, and environmental and individual risk assessments for residents. These outlined appropriate measures in place to control and manage the risks identified. There were arrangements in place for investigating and learning from incidents and adverse events involving residents. This promoted opportunities for learning to improve services and prevent incidences.

The centre was equipped with appropriate fire safety equipment, alarms and emergency lighting, and all equipment was maintained and regularly checked. However, fire evacuation drills had not been undertaken with residents living in the individual apartment. Therefore there were no assurances that residents could be evacuated in a timely manner in the event of an emergency.

There were measures in place to protect residents from being harmed or suffering from abuse. Staff had received training in the protection of vulnerable adults, and
were knowledgeable about their role in safeguarding. Money management support plans were in place for residents identified as requiring support in this area. Clear records were maintained of residents spending and finances. These were audited in a regular basis. The inspectors were therefore satisfied that people were protected from the risk of financial abuse.

Residents were provided with appropriate emotional and behavioural support. Behaviour support plans were in place for residents identified to require any interventions, and these plans provided detailed guidance to staff in meeting the needs of the individual residents. Behaviour support plans were regularly reviewed by the Quality Partner who supports the organisation with its behaviour support plans, and staff were knowledgeable in relation to any required interventions.

Communication with residents was found to be a priority in the centre. There were detailed communication plans in place for any resident who required support in this area, and assessments relating to how people communicated discomfort. Amongst the staff there was expertise in communication for people who had visual and auditory needs. Speech and language input had been sought for people needing support. All staff engaged by the inspectors could clearly communicate with residents, and could interpret for inspectors where people could not communicate verbally. There were various methods of augmentative communication in place, which clearly facilitated people to communicate, including strongly communicating dissatisfaction.

The processes in place for the management of medicines was safe and in accordance with current guidelines and legislation. A medication management policy was in place. There was a secure cupboard for the storage of medicines in the residents’ living areas. All staff had received appropriate training in the safe administration of medications. A monthly audit of practices and processes was undertaken by the pharmacist. A sample of administration and prescription sheets reviewed by the inspectors indicated that medications had been administered as prescribed. The management of medications was discussed and reviewed at team meetings.

**Regulation 10: Communication**

Residents communication needs had been assessed and were being met.

Judgment: Compliant

**Regulation 13: General welfare and development**
Residents appeared to have a good quality of life, and received care and support in accordance with their needs and preferences.

Judgment: Compliant

**Regulation 17: Premises**

Residents individual living areas were observed to be homely, accessible and promoted the privacy, dignity and safety of each resident. A number of areas had recently been re-painted with new furniture purchased in some rooms. All areas were in a good state of repair.

Judgment: Compliant

**Regulation 18: Food and nutrition**

Residents were provided with a nutritious, appetizing and varied diet.

Judgment: Compliant

**Regulation 26: Risk management procedures**

The health and safety of residents, visitors and staff were promoted and protected.

Judgment: Compliant

**Regulation 28: Fire precautions**

Suitable precautions were in place against the risk of fire with the exception of fire drills which had not been completed in the apartments.

Judgment: Substantially compliant

**Regulation 29: Medicines and pharmaceutical services**
There were systems in place to ensure the safe management and administration of medications.

Judgment: Compliant

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

Each resident’s well-being and welfare was maintained by a good standard of evidence-based care and support. However, it was identified that goals set for some residents were not specific and evidence of monitoring of progression in achieving goals set, was not always evident.

Judgment: Substantially compliant

**Regulation 6: Health care**

The resident’s healthcare needs were being met by the care provided in the centre.

Judgment: Compliant

**Regulation 7: Positive behavioural support**

Residents were provided with appropriate emotional and behavioural support.

Judgment: Compliant

**Regulation 8: Protection**

There were measures in place to protect residents from being harmed or suffering from abuse.

Judgment: Compliant
Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

<table>
<thead>
<tr>
<th>Regulation Title</th>
<th>Judgment</th>
</tr>
</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>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 19: Directory of residents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 24: Admissions and contract for the provision of services</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>Compliant</td>
</tr>
<tr>
<td><strong>Capacity and capability</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 10: Communication</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 13: General welfare and development</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 17: Premises</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 18: Food and nutrition</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 26: Risk management procedures</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 28: Fire precautions</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 29: Medicines and pharmaceutical services</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 5: Individual assessment and personal plan</td>
<td>Substantially 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>
Compliance Plan for Ardeen Cheshire Home OSV-0003456

Inspection ID: MON-0023365

Date of inspection: 16/01/2019

**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, **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:**

<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:

- All staff members have an allocated line leader and will receive at least one supervision per quarter as per Cheshire Ireland policy.

- The Operations Coordinator has developed a tracker for supervisions for all staff in Ardeen for 2019. At the end of each supervision the line leaders will set a date for the next supervision in the next quarter.

- Each quarter the Service Manager (PIC) will set an agenda focus for each supervision and set a date to have all supervision’s completed by. This agenda and date for the first quarter was sent to line leaders on the 27/2/2019. All first quarter supervisions will be completed by 31/3/2019.

- All completed supervision forms will be returned to the Operations Coordinator who will input the date of the supervision onto the tracker. These will then be filed in the Staff HR files by the Operations Coordinator.

- The Service Manager (PIC) will do an audit of the supervision tracker at the beginning of each quarter to ensure all supervisions are completed. Any findings from this audit will be brought to the monthly Senior Team Meeting and actioned where necessary.

| Regulation 28: Fire precautions | Substantially Compliant |

Regulation 28: Fire precautions - Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions:
- Fire evacuation drills of the individual apartments commenced on 15/2/2019. All apartments will have a Fire Evacuation drill completed by 31/5/2019. Thereafter there will be fortnightly fire evacuation drills of apartments. These drills are overseen by the Maintenance Coordinator who will report any findings or actions from these evacuation drills at each monthly Health and Safety meeting.

- The Service Manager (PIC) will do a quarterly audit of the fire evacuation drills to ensure all apartments have an evacuation and to ensure any actions from the evacuation drills are followed up on.

<table>
<thead>
<tr>
<th>Regulation 5: Individual assessment and personal plan</th>
<th>Substantially Compliant</th>
</tr>
</thead>
</table>

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
- All Future plans, which contain the goals for residents, will be updated by the Activities Coordinator to ensure goals are made clear and specific. This work will be completed by 26/4/2019.

- Residents’ goals will be reviewed at least 2 monthly at the care plan/future planning meeting which is overseen by the Head of Care with the Activities Coordinator in attendance.

- Regular reviews of goals with residents will take place and this will be overseen by the Activities Coordinator and documented in the Future Plans.

- The progress of all goals will be reviewed at the Annual Service review for each resident, this will be overseen by the Head of Care.

- The Service Manager (PIC) will do a Quarterly audit of Future plans to ensure goals are in place and being followed up on. Any findings from this audit will be brought to the monthly Senior Team Meeting and actioned where necessary.
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)(b)</td>
<td>The person in charge shall ensure that staff are appropriately supervised.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>31/03/2019</td>
</tr>
<tr>
<td>Regulation 28(3)(d)</td>
<td>The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>31/05/2019</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 to maximise the resident’s personal development in accordance with</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>26/04/2019</td>
</tr>
</tbody>
</table>
his or her wishes.