Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	A Middle Third
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Short Notice Announced
Date of inspection:	16 June 2021
Centre ID:	OSV-0002360
Fieldwork ID:	MON-0025942

About the designated centre

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

A Middle third is a community based home operated by St. Michael's House. The centre provides residential services for five adults both male and female with an intellectual disability. It is situated on the north side of Dublin city close to all the amenities and facilities the city has to offer. The centre is close to public transport links which enable residents to access these amenities and neighbouring areas. The building is a single-storey, five bedroom home with a homely design and layout. Each resident has their own bedroom, one of which is en-suite. There are two shared bathrooms, one with a bath and shower and the other with a shower. The house is fitted with a ceiling hoist to meet residents' needs. The kitchen is accessible and residents are encouraged to get involved with the preparation of meals and snacks. There is a garden to the rear of the property with two sheds for storage. Staff encourage residents to be active members in their communities and to sustain good relationships with their family and friends. The staff team comprises a person in charge, staff nurses, social care staff, direct care support staff and a household staff. Staffing resources are arranged in the centre in line with residents' needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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:

Date	Times of Inspection	Inspector	Role
Wednesday 16 June 2021	10:00hrs to 16:00hrs	Ann-Marie O'Neill	Lead

What residents told us and what inspectors observed

The inspector met and greeted all residents in the centre on the day of inspection. Conversations and interactions between the inspector, residents and staff took place from a two-metre distance, wearing the appropriate personal protective equipment (PPE) and was time-limited in line with National guidance.

The centre comprised of one purpose built bungalow located behind another designated centre in North County Dublin. Throughout the inspector noted a good standard of cleanliness. The centre was spacious and well lit with wide circulation areas for residents which suited their mobility aids. Bathing facilities for residents were equipped with assistance aids and residents were also provided with a Parker style bath. Overhead tracking hoists were available in some bedrooms and care and attention had been given to ensuring residents were provided with low-low beds which reduced the necessity for bed-rails.

Residents the inspector met with, were unable to provide verbal feedback on the service they received. The inspector therefore carried out observations of the residents' daily routines and observed them in their home during the inspection.

It was noted there had been an impact on residents' daily lives due to COVID-19 and restrictions had reduced their opportunities to attend their day service provision and engagement in community based activities. Some residents however, had begun to return to their day service and had started to attend for a couple of hours during the week with a view to increasing this to one full day.

The inspector observed some residents engage in baking during the course of the inspection. Staff supporting them encouraged them to weigh and measure the ingredients. Staff were overheard offering praise and encouragement throughout the steps. In other instances residents were supported to listen to music and play some music on the piano in the centre or listen to a staff member as they played songs on the piano. The provider had also appointed a day activity support worker to the centre for a number of hours each day to facilitate activities for residents.

The inspector also met a resident after returning from their day service where they had spent a couple of hours. They appeared happy and content and staff were observed engaging in a kind and pleasant manner with them and all other residents present. At this time another staff member was preparing dinner for residents which smelt appetizing and was their favourite, chicken fajitas. The inspector observed how this meal was prepared from fresh ingredients and modified to meet the different consistency requirements for all residents living in the centre.

In summary, the inspector found that resident’s well-being and welfare was maintained to a good standard, albeit impacted upon by the ongoing pandemic restrictions.

However, improvements were required in a number of key areas. Improved nursing staff resources were required to ensure residents received nursing care staff that were familiar and knowledgeable of residents' individual personalities and specific health care and medication plans.

While improvements had been made to the medication administration system in the centre, further improvements were required to the manner in which medications were ordered, received and stock checked. The inspector noted a number of regularly occurring medication errors recorded in the centre were as a result of poor ordering and stock check arrangements which could be mitigated through a more robust system.

Staff training arrangements required improvement and particular attention was required in relation to first aid training to meet the health care needs for some residents.

The next two sections of this report present the inspection findings in relation to governance and management in the centre, and how governance and management affected the quality and safety of the service being delivered.

Capacity and capability

For the most part, the governance and management arrangements ensured safe, quality care and support was received by residents.

However, improvements were required to ensure nursing whole-time-equivalent staffing arrangements were in line with the matters as set out in the statement of purpose for the centre. In addition, there were a number of gaps found across all areas of refresher training for staff. The provider was also required to ensure all staff working in the centre had knowledge and skills in the area of first aid in order to respond to the health care needs of some residents.

There was a person in charge was employed in a full-time capacity and had the necessary experience to effectively manage the service. The provider had ensured the person in charge appointed met the requirements of Regulation 14 in relation to management experience and the required qualifications necessary for the role. The person in charge was clinical nurse manager 2 (CNM2). They were supported in their role by a clinical nurse manager (CNM1). Both nurse managers generally worked on opposite shifts which ensured management and clinical oversight arrangements were present in the centre.

The provider had carried out an annual review of the quality and safety of the service for 2020, and there were quality improvement plans in place, where necessary. There were also arrangements for unannounced visits to be carried out on the provider's behalf on a six-monthly basis as required by the regulations. The inspector reviewed the most recent six-monthly provider visit and noted they were

comprehensive in scope and provided a quality improvement action plan for the person in charge to address.

However, improvements were required in relation to the systems in place for auditing medication management systems in the centre. While the person in charge carried out medication management audits, these had not been effective in identifying trends or root causes in relation to medication errors that occurred in the centre. For example, on reviewing a sample of recorded medication errors, the inspector identified that a number of these errors were as a result of poor ordering and stock control practices in the centre. However, the most recent medication audits completed had not identified any deficits in these systems.

Overall, there were sufficient staff working each day to meet the assessed needs of residents. A planned and maintained roster, that reflected the staffing arrangements in the centre, was in place. Observations made throughout the inspection noted kind and helpful interactions between residents and staff. However, improvements were required.

At the time of inspection the centre was operating with a whole-time-equivalent deficit of 2.5 nursing staff. The inspector noted nursing staff were available in the centre each day and night as per the matters set out in the statement of purpose. However, in order to ensure this agency nurses and nurses from a relief staff panel were utilised in the centre. While this ensured nursing support was available for residents, a number of residents living in the centre required care and nursing support from workers that knew them well and had built up a rapport with them over time.

There were arrangements in place to ensure staff had access to training and refresher training. However, there were a number of gaps in refresher training across all areas reviewed. In addition, it was not demonstrated the person in charge had effective oversight arrangements in relation to staff training. At the time of inspection the person in charge maintained individual training records for staff, however, they had not created a staff training oversight system which would provide them with readily accessible information and oversight of gaps and training due dates. This required improvement.

Furthermore, the inspector identified a key health care need for a resident that required first responder and/or first aid training for staff working in the centre. However, on review of training records in the centre it was not demonstrated all staff had received such training. This was required in light of a recent incident whereby staff working in the centre were required to implement a first aid response to a resident with an underlying condition that could require such intervention again.

Arrangements were in place to supervise staff, the inspector noted staff had received a supervision meeting with the person in charge and/or CNM1 and within the time-frame as set out in the provider's supervision policy.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted a complete application to renew registration.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was found to be knowledgeable of the needs of residents and had the required social care and management experience to meet the requirements of Regulation 14.

Judgment: Compliant

Regulation 15: Staffing

The person in charge maintained a planned and actual roster and it was noted that appropriate staffing support arrangements were in place to meet the assessed needs of residents each day and night.

However, there was a 2.5 whole-time-equivalent deficit of nursing staff for the centre. The provider was required to address this nursing resource deficit to ensure residents' nursing care needs were supported by stable and consistent staff.

Schedule 2 files were not reviewed on this inspection.

Judgment: Not compliant

Regulation 16: Training and staff development

There were a number of gaps in refresher training across all areas reviewed.

It was not demonstrated the person in charge had effective oversight arrangements in relation to staff training.

The inspector identified a key health care need for a resident that required first responder and/or first aid training for staff working in the centre. However, on review of training records in the centre it was not demonstrated all staff had

received such training.

Arrangements were in place to supervise staff, the inspector noted staff had received a supervision meeting with the person in charge and/or CNM1 and within the time-frame as set out in the provider's supervision policy.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had ensured appropriate clinical governance in the centre by appointing a CNM2 and CNM1 to perform the roles of person in charge and deputy manager to the person in charge.

The provider had carried out an annual review of the quality and safety of the service for 2020.

There were arrangements for unannounced visits to be carried out on the provider's behalf on a six-monthly basis as required by the regulations.

However, improvements were required in relation to the systems in place for auditing medication management systems in the centre. While the person in charge carried out medication management audits, these had not been effective in identifying trends or root causes in relation to medication errors that occurred in the centre.

Judgment: Substantially compliant

Quality and safety

Overall, it was demonstrated the provider had the capacity and capability to provide a reasonably good quality, safe service to residents. Some areas of improvement were required to enhance the quality of care and support to residents. Medication management systems required improvement in order to mitigate and reduce the causes of some medication errors that occurred in the centre. While residents' health care was overall appropriately managed, some improvement was required to ensure care plans outlined clearly specific information in order to guide staff.

The provider and person in charge had ensured appropriate fire safety precautions were in place in the centre. Fire and smoke containment measures were in place, fire doors were located throughout the premises. Hold open and door release mechanisms were in place on fire doors which further enhanced their containment

effectiveness.

Servicing records for the fire alarm, fire extinguishers and emergency lighting were up to date. Each resident had a personal evacuation procedure in place. Fire evacuation drills had been completed and documented to review the effectiveness of the evacuation plans for residents.

A review of safeguarding arrangements noted residents were protected from the risk of abuse by the provider's implementation of National safeguarding policies and procedures in the centre. The provider had ensured staff were trained in adult safeguarding policies and procedures. Some staff however, had not received refresher training in safeguarding, this finding is addressed under Regulation 16: Staff Training and Development.

There was evidence of responsive review and actions taken on foot of the findings from the previous inspection. Previously it had been identified there was a safeguarding concern which related to the behavioural presentation of some residents at night time. There was evidence which demonstrated comprehensive behaviour reviews and planning had been implemented to address this and had been effective.

Each resident had an up-to-date personal plan in place. An assessment of need had been completed for each resident which also included an allied professional framework and recommendations which informed the development of support planning for residents. Daily recording notes were maintained and personal plans were updated following review by allied professionals.

As discussed, where positive behaviour support arrangements were required to meet the assessed needs of some residents appropriate arrangements had been put in place. Positive behaviour support assessments and plans were detailed, comprehensive, developed by an appropriately qualified person, up-to-date and reviewed regularly.

Overall, there were a number of restrictive practices utilised in the centre. Where such practices were in use, they were to manage a specific risk and had been referred to the provider's positive approaches monitoring group for approval and ongoing review. The inspector noted the use of low-low beds in the centre and crash mats which demonstrated efforts to reduce and eliminate restrictive practices where possible.

The provider had ensured that systems were in place for the prevention and management of risks associated with COVID-19. Staff were observed wearing personal protective equipment (PPE) correctly during the course of the inspection. Centre-specific and organisational COVID-19 risk assessments were in place. The provider and person in charge had ensured that all staff were made aware of public health guidance and any changes in relation to this.

PPE was in good supply and hand-washing facilities were available in the centre. Alcohol hand gel was present at key locations in the centre for staff and residents to use. Each staff member and resident had their temperature checked daily as a

further precaution. Appropriate access to general practitioners (GPs) and public health testing services was also available for the purposes of reviewing and testing residents and staff presenting with symptoms of COVID-19.

Each resident's health care needs were met appropriately in the centre and reviewed regularly through an allied health professional framework and physicians linked with each resident's care. Corresponding health care plans were also in place which outlined, for the most part, adequate information and detail to guide and inform staff involved in the resident's care.

However, some improvement was required to ensure these plans included more detail with regards to specific nursing care interventions. For example, where residents were prescribed oxygen as part of their seizure response plan, the prescribed dosage of oxygen was not documented in the plan.

Improvements were required in relation to the systems for ordering and stock checking of medication in this centre. The person in charge had made improvements to residents' medication administration records following the previous inspection. This had addressed the findings of the previous inspection, however, medication errors continued to occur.

On review of a sample of documented medication errors, it was demonstrated a number of these errors could be attributed to poor stock control and ordering systems. On some occasions, medication errors occurred due to resident's medication not being in stock in the centre, for example.

The inspector reviewed the stock control systems in place and noted stock checks were not carried out frequently enough to reflect the actual stock of the medications available in the centre. In addition, it was not clearly demonstrated if the ordering and supply arrangements were effective enough to ensure resident's prescribed medications were always available in the centre for staff to administer. This required improvement.

Regulation 27: Protection against infection

There were procedures in place to follow in the event of a COVID-19 outbreak in the centre, with contingency plans available.

There was adequate PPE available and there were sufficient hand-washing and sanitising facilities present.

Staff were observed to wear PPE during the inspection and encourage and maintain social distancing procedures with residents and staff.

COVID-19 risk assessments had been drafted by the person in charge outlining the control measures for mitigating infection control risks in the centre.

Plans were in place to support residents to self-isolate should it be necessary in the event of a suspected or actual case of COVID-19.

Judgment: Compliant

Regulation 28: Fire precautions

The provider and person in charge had ensured appropriate fire safety precautions were in place in the centre.

Fire and smoke containment measures were in place, fire doors were located throughout the premises.

Servicing records for the fire alarm, fire extinguishers and emergency lighting were up to date.

Each resident had a personal evacuation procedure in place. Fire evacuation drills had been completed and documented to review the effectiveness of the evacuation plans for residents.

There were effective fire safety oversight arrangements in place to identify if and when fire drills had not taken place in the time-lines as set out in the provider's fire safety policy.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Improvements were required in relation to the systems for ordering and stock checking of medication in this centre.

On review of a sample of documented medication errors, it was demonstrated a number of these errors could be attributed to poor stock control and ordering systems. On some occasions, medication errors occurred due to resident's medication not being in stock in the centre, for example.

It was not clearly demonstrated if the ordering and supply arrangements were effective enough to ensure resident's prescribed medications were always available in the centre for staff to administer. This required improvement.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Each resident had an up-to-date personal plan in place.

An assessment of need had been completed for each resident which also included an allied professional framework and recommendations which informed the development of support planning for residents.

Daily recording notes were maintained and personal plans were updated following review by allied professionals.

Judgment: Compliant

Regulation 6: Health care

Each resident's health care needs were met appropriately in the centre and reviewed regularly through an allied health professional framework and physicians linked with each resident's care.

Health-care plans were in place which outlined, for the most part, adequate information and detail to guide and inform staff involved in the resident's care.

However, some improvement was required to ensure these plans included more detail with regards to specific nursing care interventions.

For example, where residents were prescribed oxygen as part of their seizure response plan, the prescribed dosage of oxygen was not documented in the plan.

Improvement was required to ensure where a health care risk was identified, a corresponding health care plan was in place.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Positive behaviour support plans were comprehensive, based on an assessment, developed by an appropriately skilled and qualified allied professional and reviewed regularly and updated.

There was evidence of comprehensive assessment and intervention by allied professionals in supporting residents behaviour support needs, in particular at night

time, which had in turn helped to address a safeguarding concern.

A number of restrictive practices were implemented in this centre, however, it was demonstrated where possible, alternative measures were implemented, for example the use of low-low beds and crash mats.

Where such practices were implemented, they were to manage a specific personal risk and had been regularly reviewed by the provider's positive approaches management committee.

Judgment: Compliant

Regulation 8: Protection

The provider had ensured appropriate safeguarding policies and procedures were in place and there was evidence to demonstrate their implementation in the centre.

Staff had received training in safeguarding vulnerable adults and refresher training was made available to staff, although some gaps were noted. This is addressed under Regulation 16: Staff training and Development.

Through the implementation of positive behaviour support interventions a safeguarding concern, identified on the last inspection, had been addressed.

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:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for A Middle Third OSV-0002360

Inspection ID: MON-0025942

Date of inspection: 16/06/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Recruitment process within SMH is on-going to fill the nursing staff vacancies in the centre. New staff members will be joining the team once recruitment, vetting and organizational orientation are completed. • In as far as possible regular relief/agency staff are booked in as far advance as possible to support consistency in the team	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Training records will be reviewed and updated by PIC on a monthly basis • Correspondance made with training department to highlight the need and urgency for first aid training for all staff in the centre • All outstanding online training will be completed by all staff by 30/08/2021	
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: • PIC will review current medication auditing systems to establish and action any deficits identified through this process • Medication management will be included as set agenda item on staff meetings from August 2021 • Review of the current systems in the centre for ordering and stock checking of medications carried out. • Monthly bulk medication delivery from Pharmacy has been changed to weekly to decrease the amount of stocks kept in the centre. • Medication audits will be carried out weekly as opposed to monthly as the supplies are delivered to the centre. In addition a daily medication audit is carried out for one resident's medication stock per day this informs pharmacy ordering of medications which takes place once per week and or as required in addition to this. • Any identified stock issues will be escalated to PIC for follow up	
Regulation 29: Medicines and pharmaceutical services	Not Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: • Review of the current systems in the centre for ordering and stock checking of medications carried out. • Monthly bulk medication delivery from Pharmacy has been changed to weekly to decrease the amount of stocks kept in the centre. • Medication audits are carried out weekly as the supplies are delivered to the centre. In addition a daily medication audit is carried out one resident's medication stock per day this informs pharmacy ordering of medications which takes place once per week and or as required in addition to this. • Any identified stock issues will be escalated to PIC for follow up	

Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: • All Residents healthcare Support plans will be reviewed and updated as required to ensure all health care risks have a correesponding health care plan in place • All residents MAS will be reviewed with a view to informing healthcare support plans	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/12/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	31/08/2021
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Substantially Compliant	Yellow	31/10/2021

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	31/10/2021
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	31/08/2021