



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

## Issued by the Chief Inspector

Name of designated centre:	Glenbow Services
Name of provider:	Health Service Executive
Address of centre:	Sligo
Type of inspection:	Short Notice Announced
Date of inspection:	05 August 2021
Centre ID:	OSV-0003364
Fieldwork ID:	MON-0033348

## About the designated centre

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

Glenbow Services is run by the Health Service Executive and is located a short distance from a town in Co. Sligo. The centre provides residential care for up to eleven male and female residents, who are over the age of 18 years and have mild to profound intellectual disabilities. The centre is based on a campus setting and comprises of two bungalow dwellings located within close proximity to each other. Residents have access to their own bedroom, some en-suite facilities, shared communal areas, bathrooms and each bungalow provides residents with level access to a green area. Staff are on duty both day and night to support the residents who avail of this service.

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:	8
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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
Thursday 5 August 2021	9:30 am to 5:34 pm	Stevan Orme	Lead
Thursday 5 August 2021	9:30 am to 5:34 pm	Alanna Ní Mhíocháin	Support

## What residents told us and what inspectors observed

In this centre there was evidence of a good quality, person-centred service that addressed the needs of the residents. Inspectors met with residents, made observations, reviewed documents and spoke with staff. All of this indicated that the residents were comfortable in their home and received good quality care and support.

In order to adhere to COVID-19 guidelines and minimise disruption to the residents, inspectors visited the designated centre in the morning. Inspectors briefly met with residents and staff, and an inspection of the premises was conducted at this time. Inspectors then re-located to a nearby office in order to review documentation. Inspectors visited the centre again in the afternoon and held longer discussions with residents and staff. Appropriate face-mask and COVID-19 prevention guidelines were in place throughout the inspection.

This centre comprises of two bungalows that are located in a campus setting and are next-door to each other. On entering the centre, inspectors observed that the houses were clean and welcoming. A COVID-19 sanitization station was set-up inside the front door of each house with sign-in sheets for contact tracing. Each resident had their own bedroom which was decorated to their own taste. There was adequate storage in each room and adequate space to meet the resident's needs. Where required, residents had profiling beds. Bathrooms were clean and had level showers. The centre was fully wheelchair accessible with level flooring and wide doorways. The centre was personalised with the residents' photographs, posters of their interests, and with their artwork. The house was nicely decorated and in good structural repair. However, there was some damage to the floor of one dining room which had been reported by the person in charge to the maintenance department and was due for repair by the end of the month. Notice boards were located at various points in the house providing information for residents in picture-based format. Each house contained a kitchen but main meals were prepared in a central location on the campus and delivered to the centre. There were fire doors located in the kitchens and bedrooms of each house. One house had new fire doors in place. However, the fire doors in the kitchen of the second house were reported to be in place for over 30 years and had not been surveyed to assess their safety should a fire occur in the kitchen. This will be further discussed later in the report. There was a shed at each house that housed laundry facilities for the residents' use.

Outside, the residents had access to a large campus and grounds. Plans were in place to install a tarmac patio outside one house and works had commenced. There were raised beds that were in the process of being painted by one resident.

Inspectors met with eight residents in the centre. The residents were going about their daily routines and interacted with inspectors on their own terms. Residents appeared comfortable and at ease in their home. Each resident was introduced to inspectors by the person in charge. One resident spoke of his satisfaction with his

home, the staff who work there and the service he receives. He reported that he is happy in his home and that he feels comfortable addressing any concerns with the staff. He reported that if he wants anything he can ask the staff. He talked about his excitement at upcoming plans to visit family. He enjoys going for a walk daily and was accompanied by a staff member on a walk after his conversation with inspectors.

Direct personal contact with family had been difficult for residents in light of COVID-19 restrictions, but residents were supported to make calls and some had been able to receive visitors since restrictions had eased.

Staffing numbers in the centre were found to be inadequate to meet the assessed needs and safety risks of the residents. The staffing arrangements in the statement of purpose, which was made available to inspectors on the day of inspection, outlined that the centre should be staffed by five staff members during the day; three staff members in one house and two in another. On the day of inspection, there were only four members of staff on duty. A review of the roster indicated that there had been multiple occasions over the last number of weeks where this had also occurred. Inspectors observed that when two staff members were required to assist a resident with personal care, other residents were left unsupervised. Some of these residents were assessed as requiring one-to-one supervision to ensure that they did not fall when trying to mobilise. Staff were observed reminding one particular resident to stay seated and call if they needed assistance. In addition to this, the number of staff outlined in the statement of purpose was not sufficient to support residents to engage in social or personal activities. As some residents require two-to-one assistance, additional staff would be required to support residents engage in social activities inside and outside of the centre.

Staff interacted with the residents in a warm and empathetic manner. Staff were knowledgeable on the communication styles of the residents and were observed chatting and interacting with residents in a friendly manner. Staff were knowledgeable on the residents' likes and dislikes and spoke about residents in a respectful manner. Staff were observed responding to residents' non-verbal cues when they were looking for assistance.

Staff spoke about the ways in which residents are offered choice and have control over their daily routine. Staff told inspectors that residents are offered choice at all mealtimes and alternatives are arranged if the resident does not want the food that has arrived from the kitchen. Residents are also facilitated to eat their meals at a time of their choosing. Residents have been offered opportunities to be involved in some activities that are provided in the day services on campus. The right of residents to refuse to partake in these activities has also been respected. However, the assessment and planning of personal and social activities required improvement. A review of daily notes and personal plans indicated that some residents had a limited variety of activities in their days. While it was noted that COVID-19 restrictions had impacted on social activities, there had been little change in some residents' daily activities with the easing of restrictions. Inspectors found that activities were largely campus-based with little engagement in community activities

and did not reflect the interests, capacities and needs of some residents.

Overall, the inspectors found that the service provided was person-centred and of a good standard. The centre itself is a very pleasant home. Inspectors observed that the staff showed empathy and respect in all dealings with the residents and that the residents were supported in their daily activities. The residents were comfortable with the staff and appeared at-ease in their home.

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

## Capacity and capability

Overall, there were systems in place to ensure that the service provided was safe, consistent and appropriate to the residents' needs. However, improvements were required in the areas of staffing, staff training, and the governance and management of the service.

The centre was operated by the Health Service Executive and the centre was managed by the person in charge who worked full-time in the centre and had the skills and experience to necessary to manage the centre. She had a good knowledge of the residents' needs and the arrangements in place to meet those needs.

As outlined above, staffing arrangements in the centre did not meet the assessed needs of the residents and address the risks identified by the provider. Inspectors also examined the training records of staff which outlined eight core training areas that the provider deemed necessary for all staff. Refresher training was required every three years in these areas. The training matrix indicated that while some staff had up-to-date training in all areas, there were gaps in the training matrix where a number of refresher training courses had not been completed by some staff. This was confirmed by the person in charge. Access to online training was a challenge due to the recent cyber-attack and there were plans to provide some in-house training in behaviour management. However, some staff had not received refresher training in this area since 2016.

There was evidence of a clear complaints procedure in this centre. Residents were knowledgeable on how to make a complaint and reported that they would be happy to bring any concerns to the attention of staff. The complaints procedure was outlined in picture-format in the centre. The provider had evidence of processing a complaint and adequately addressing the concerns raised.

Overall, there was good governance and management of the centre with clear

reporting structures within the service. Plans were in place to ensure that a person in charge from one of the centres on the campus was on-call at weekends and outside of routine hours. The provider had completed 6-monthly audits and annual reviews of the service with a quality improvement plan developed to address issues that were identified. However, the provider had not ensured that the centre was adequately resourced to deliver support in line with the residents' assessed needs and to engage in activities in the centre or the local community. In addition, the provider had not adequately assessed the risk posed by the staffing numbers and had not identified all risks in the centre, specifically in relation to the fire doors in one kitchen.

### Regulation 15: Staffing

The number of staff in the centre was not adequate to meet the assessed needs of the residents and to address the identified risks. Staff numbers were not sufficient to support residents engage in social or personal activities in the centre or in the local community.

Judgment: Not compliant

### Regulation 16: Training and staff development

Training in eight core areas had been identified by the provider. While some staff had up-to-date training in these areas, there were a number of staff who required refresher training in more than one course for example hand hygiene, children first and open disclosures .

Judgment: Substantially compliant

### Regulation 23: Governance and management

There were clear reporting relationships in this service. The provider had completed audits and annual reviews which fed into a quality improvement plan. However, the provider had not ensured that the centre was adequately resourced to deliver support in line with the residents' assessed needs and to engage in activities in the centre or the local community.

Judgment: Substantially compliant



## Regulation 34: Complaints procedure

There was an effective complaints procedure in place for residents. There was evidence that residents could make a complaint and issues raised had been adequately addressed by the provider.

Judgment: Compliant

## Quality and safety

Residents' well-being and welfare was maintained by a good person-centred service in this centre. However, improvements were required to the development of accessible personal plans, access to social activities to support the general welfare of the residents, training in relation to behaviour support, and risk management.

The centre itself was a homely, comfortable building that catered to the needs of the residents. There were plans in place to make additional enhancements to the building in terms of floor coverings, patios and raised gardening beds. The grounds around the centre provided a nice area for walking. However, access to a bus would be required to travel to the nearest town.

The health needs of the residents were well managed in this centre. Residents had robust health plans that were regularly updated and adjusted as appropriate. There was adequate monitoring of the residents' healthcare needs and evidence of input from a variety of health professionals. The provider had plans in place to allow a resident to isolate in their home in cases of suspected or confirmed COVID-19. In addition to the comprehensive healthcare goals, residents' personal plans also contained social and personal goals that were regularly reviewed. Staff were knowledgeable of the residents' health and social needs. However, although some documents had been developed in a picture-based easy-read format, these were not specific to each of the residents' goals or communication needs and therefore, were not accessible to the residents.

Residents' personal plans also contained their personal risk assessments. In addition, the provider had maintained a risk register outlining the risks identified in the centre. The person in charge was knowledgeable of the most pertinent risks in the centre including falls, access to training, COVID-19, tissue viability and community access for the residents. An incident log was kept of any incidents and were reported on the National Incident Management System and actioned. However, the impact of low staffing numbers on the residents' needs and a full risk assessment of fire safety, namely older fire doors, had not been identified and conducted.

The communication needs of the residents were supported by staff. Residents had a

communication profile that was updated regularly. The person in charge and staff were knowledgeable of the residents' needs and were familiar with their behaviours, preferences and dislikes. This enabled them to understand the residents' communication style and to interpret their needs and wants. There were picture-based easy-read notifications and posters in the centre for the residents. Staff had training on specific communication strategies (e.g. Lámh) and were observed using these strategies with residents. Staff were observed conversing with residents and could support their requests by interpreting their non-verbal communication.

A log of restrictive practices was kept in the centre with clear rationale outlined. There was a record of the use of these practices and this was regularly reviewed. Staff were knowledgeable of these practices and the needs of residents who presented with behaviours of concern. Staff could identify triggers for these behaviours and knew the strategies to support residents. Behaviour support plans were regularly reviewed by a Behaviour Support Therapist and staff were knowledgeable of these plans. However, training specific to managing behaviours of concern was not up-to-date and in line with the provider's policy on mandatory training.

There was evidence of good safeguarding measures in the centre. Staff were knowledgeable on the steps to be taken if they had any concerns regarding safety or abuse of a resident. Information regarding the designated officer and how to contact them was displayed in the centre. Safeguarding plans were in place where issues had been identified and time-framed measures were in place to protect the residents.

The residents' rights were respected by offering and respecting their choice in their daily activities. Each resident had access to their own private room. Residents were offered the opportunity to engage in activities on the campus and in the house. If they declined to engage in these activities, this was also respected. However, as outlined previously, some residents were found to have a limited range of activities available that did not reflect their interests, capacities and needs.

Overall, the residents in this centre have a good quality, safe service. Staff are very familiar with the residents and are warm and respectful in their interactions. Residents appear comfortable and at ease in their home and with the staff. Staff are able to support the residents' with their health, behavioural and communication needs. However, further development of an accessible personal plan, social activities to reflect the residents' interests and capabilities, and a comprehensive risk assessment of the centre is required to improve the quality of this service.

## Regulation 10: Communication

Residents are assisted and supported with their communication needs. Each resident has a communication plan that is regularly updated. Staff are knowledgeable of

strategies that support residents' communication and were observed using these during the inspection.

Judgment: Compliant

### Regulation 13: General welfare and development

Some residents have opportunities to engage in social and personal activities. However, a review of daily notes indicated that some residents have limited opportunities to engage in activities that were in line with their interests, capacities and needs.

Judgment: Substantially compliant

### Regulation 17: Premises

The centre was appropriate to the needs of the residents. It was clean, suitably decorated and in good structural repair. The centre was accessible to all residents.

Judgment: Compliant

### Regulation 26: Risk management procedures

The provider had a risk register in place, personal risk assessments for all residents and had a log of reported incidents. There was evidence that risks identified on audit were actioned and addressed by the provider. However, risks in relation to the impact of low staffing numbers on residents and the effectiveness of fire containment equipment had not been identified or assessed.

Judgment: Substantially compliant

### Regulation 27: Protection against infection

The provider had taken adequate measures to protect residents from infection. This included COVID-19 sanitization and contact tracing forms, as well as a housekeeper and regular cleaning of the centre.

Judgment: Compliant

### Regulation 5: Individual assessment and personal plan

There were detailed personal plans available that assessed the health and social care needs of the residents. Goals were set and there was evidence of regular review. However, plans were not available to residents in an accessible format.

Judgment: Substantially compliant

### Regulation 6: Health care

The healthcare needs of the residents were well managed. There were comprehensive health plans with evidence of input from a variety of health professionals. Plans were regularly reviewed and updated.

Judgment: Compliant

### Regulation 7: Positive behavioural support

Residents who required support with behaviours of concern had behaviour support plans in place. These were regularly reviewed by a Behaviour Support Therapist and staff were knowledgeable of their content. However, staff training in relation to behaviour support was not in line with the provider's training policy.

Judgment: Substantially compliant

### Regulation 8: Protection

There were adequate safeguarding measures in place in the centre. Safeguarding plans were in place where issues had been identified. Staff were knowledgeable on what steps should be taken if there were any concerns regarding abuse.

Judgment: Compliant

## Regulation 9: Residents' rights

Residents were routinely offered choice in their daily activities and these choices were respected. Residents participated in regular meetings in order to have input into the running of the centre.

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
<b>Capacity and capability</b>	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
<b>Quality and safety</b>	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

# Compliance Plan for Glenbow Services OSV-0003364

Inspection ID: MON-0033348

Date of inspection: 05/08/2021

## 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
<p>Outline how you are going to come into compliance with Regulation 15: Staffing: To ensure compliance with Regulation 15: Staffing the following actions have been undertaken;</p> <ul style="list-style-type: none"> <li>• The Risk assessment on impact of reduced staffing on residents updated on the 12/8/21</li> <li>• A staffing review has been completed and additional staff have been identified for Glenbow Service. Two staff will commence on week beginning 30/8/21 and one additional staff will commence week beginning 13/9/21. This additional staffing ratio will meet the assessed needs of each resident to include support to engage in activities in accordance with their will and preference.</li> </ul>	
Regulation 16: Training and staff development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development: To ensure compliance with Regulation 16: Training and Staff Development the following actions have been undertaken;</p> <ul style="list-style-type: none"> <li>• All outstanding training to include Fire Prevention, Safeguarding and behavior support training will be completed by the 30th September 2021.</li> <li>• Fire Prevention is scheduled for 2 staff on 1/9/21 and 27/9/21.</li> <li>• Safeguarding and Protection of Vulnerable Adults has been completed for 1 staff on the 31/8/21</li> </ul>	



- 4 staff are scheduled for Behavior Support Training on the 14th and 28th September 2021
- Staff will submit attendance record/ certificate of training and update training records in Designated centre
- PIC will Audit training records on a quarterly basis to ensure compliance with Service Mandatory training schedule.

Regulation 23: Governance and management	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 23: Governance and management:

To ensure compliance with Regulation 23: Governance and Management the following actions have been undertaken;

- Management systems have been reviewed to ensure risk assessment are completed reviewed and updated as appropriate. Risk rating will also be reviewed
- The skill mix and number of staff for the Centre will be kept under constant review to ensure sufficient staffing levels are in place to meet the assessed needs of all residents.
- All mandatory training will be completed by 30/9/21
- Staff will submit attendance record/ certificate of training and update training records in Designated centre
- PIC will Audit training records on a quarterly basis to ensure compliance with Service Mandatory training schedule.

Regulation 13: General welfare and development	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 13: General welfare and development:

To ensure compliance with Regulation 13: General Welfare and Development the following actions have been undertaken;

- All personal plans have been reviewed, and goals and activities updated in line with residents will and preference and progress on these goals documented in Person centered plan
- Residents are supported by named keyworkers to engage in meaningful activities as per their will and preference daily and this is clearly documented in each resident's

person-centered plan.

Regulation 26: Risk management procedures

Substantially Compliant

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

To ensure compliance with Regulation 26: Risk management Procedures the following actions have been undertaken;

- The Risk Register for the Centre and all has been reviewed.
- Fire risk assessment has been reviewed and outstanding fireworks identified.
- 12 new fireproof doors will be installed with intumescent seals and brushes.
- The 2 areas within the centre will be networked to the main fire alarm system and certification of remedial works will be completed by the 10/10/21.

Regulation 5: Individual assessment and personal plan

Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

To ensure compliance with Regulation 5: Individual Assessment and Personal Plan the following actions have been undertaken;

- Communication plans in place for each resident have been reviewed by the Speech and Language Team in terms of communication method.
- The communication teams have identified the "Show Me "tool as an alternative Person Centered Planning tool for residents that will assist in developing and planning personalized goals in an accessible format with each resident
- The Speech and Language team will provide staff training in alternative Person Centered Plan format to support the development of more accessible personal plans with residents.

Regulation 7: Positive behavioural support	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:</p> <p>To ensure compliance with Regulation 7: Positive Behavior Support the following actions have been undertaken;</p> <ul style="list-style-type: none"><li>• 4 staff are scheduled to receive Positive Behavior support training on the 14th and the 28th September 2021 in a blended learning format to include both face to face and online elements.</li><li>• Staff will submit attendance record/ certificate of training and update training records in Designated centre</li><li>• PIC will Audit training records on a quarterly basis to ensure compliance with Service Mandatory training schedule.</li></ul>	

## 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 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	13/09/2021
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	13/09/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to	Substantially Compliant	Yellow	30/09/2021

	appropriate training, including refresher training, as part of a continuous professional development programme.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	16/08/2021
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	10/10/2021
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Substantially Compliant	Yellow	16/12/2021
Regulation 07(2)	The person in charge shall ensure that staff receive training in	Substantially Compliant	Yellow	30/09/2021

	the management of behaviour that is challenging including de-escalation and intervention techniques.			
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