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

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| Name of designated centre: | Ardeevin |
| Name of provider: | Saint Patrick's Centre (Kilkenny) |
| Address of centre: | Kilkenny |
| Type of inspection: | Short Notice Announced |
| Date of inspection: | 07 October 2020 |
| Centre ID: | OSV-0005777 |
| Fieldwork ID: | MON-0030176 |

## About the designated centre

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

Ardeevin designated centre provides community based living arrangements for up to four adult residents. Ardeevin is a modern and spacious property that provides residents with a high standard living environment which meets their assessed mobility and social care needs. Each resident has their own bedroom. This service provides supports for residents with severe to profound intellectual disabilities and complex needs. The provider identifies that residents living in this centre require high levels of support and has staffing arrangements in place to ensure residents needs are met. There is a full-time person in charge assigned to the centre, minimum of two staff during the day to support residents in having a full and active life and one waking night staff in place also. The centre is resourced with one transport vehicle to support residents' community based activities.

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

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| Number of residents on the date of inspection: | 4 |

## 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 7 October 2020 | 09:00hrs to 15:00hrs | Laura O'Sullivan | Lead |

## What residents told us and what inspectors observed

The inspection took place during the COVID 19 pandemic and was completed by the inspector in accordance with national guidance. All social interactions were undertaken with social distancing in place and personal protective equipment was worn as required. A private area in a sun room was utilised to complete documentation reviews. From this space the inspector could observe the coming and goings of the centre.

The inspector was greeted on arrival to the centre by one resident. Formal introductions were made by staff supporting them. Other residents were going about their morning routine with some sitting at the breakfast table having a cup of tea. Staff were observed providing supports in a professional and dignified manner ensuring to interact with the resident throughout. This was observed throughout the day.

Varying levels of activity were observed for residents. One resident headed out for the morning to complete household tasks with their support staff. The other remaining three residents were observed to spend long periods of time sitting in the living room listening to music. One individual spent periods of time sleeping on their bean bag. This resident one occasion took the inspectors hand and brought them to the front door, communicating they wished to go for a walk. Due to one staff only remaining in the centre this could not be facilitated. Another individuals' morning activity was going for a walk in the back garden and bringing their laundry to the utility room.

In the living room area each resident had a personalised white board setting out their choice of activities for the day. These included such activities as "Anam". These were not observed to be completed.

## Capacity and capability

The inspector reviewed the capacity and capability of the registered provider to deliver a safe and effective service within Ardeevin. Whilst areas of good practice were observed, improvements were required to ensure compliance with regulations was achieved. The areas of non-compliance will be addressed within this report.

The registered provider had ensured the appointment of a suitably qualified and experienced person in charge to the centre. This individual possessed a clear understanding of their regulatory role and the needs of the residents, including the notification of all required incidents to the chief inspector of social services. They held this governance role in three designated centres. On the day of the inspection

they had been rostered to provide direct support however, due to their governance responsibilities this was not feasible. The person in charge reported directly to the person participating in management.

The registered provider had ensured measures were in place for organisational oversight of service provision within the centre. This incorporated an annual review and six monthly unannounced visits to the centre. These monitoring systems were found to be comprehensive and set out actions which were required to address identified areas of concern. Whilst, a staffing vacancy was identified in the most recent unannounced visit, the report did not highlight the impact of this on the quality of life of residents. Some actions set out in these systems were not addressed within the allocated time frame, for example, evidence of follow through of complaints.

At centre level, the person in charge delegated a number of monitoring systems to the staff team. These duties were incorporated into formal supervision meetings, with the person in charge partaking in a mentor role to enhance the quality of all tools utilised. The person in charge reviewed the completed audits and developed any relevant actions to address identified areas of improvement. These included fire safety audits, hygiene audits and a daily shift planner.

The registered provider had not ensured the staffing allocated to the centre was appropriate to the assessed needs of the residents. Within the statement of purpose the provider set out that the staffing in the centre was minimum of two staff with a third staff to assist residents to participate in meaningful activities. As stated previously, on the day of inspection the third staff rostered was the person in charge. They were not present to support with activities as they had governance responsibilities to attend to. This resulted in a number of residents spending long periods of time sitting in the living room or sleeping on a chair. Upon review of the roster, most days the centre was staffed with two staff members. Staff members present did articulate that due to this it can be very difficult to facilitate all residents' choice of activities.

The registered provider had provided a complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure. Improvements were required at centre level to ensure adherence to these procedures. Two versions of the complaints policy were available on site. Actions identified within the annual review and a six monthly visit remained unaddressed despite a complaints audit stating no action was required. This was with respect to the maintenance of records for complaints being maintained within the centre. This included evidence of communication with complainant and the satisfaction of the complainant within the outcome.

The registered provider had ensured the development of the policies and procedures as set out under schedule 5 of the Health Act. However, a number of these had not been reviewed within a three year period including the monitoring and documentation of nutritional intake. The review of polices was essential in ensuring staff were aware of the best practice in their support of residents.

## Regulation 14: Persons in charge

The registered provider had appointed a suitably qualified and experienced person in charge to the centre.

Judgment: Compliant

## Regulation 15: Staffing

The registered provider had not ensure the staffing allocated to the centre was appropriate to the assessed needs of the residents.

Judgment: Not compliant

## Regulation 16: Training and staff development

The person in charge had ensured that staff were appropriately supervised in accordance with local policy.

The person in charge had ensured staff had access to appropriate training, including refresher training as part of a continuous professional development programme.

Judgment: Compliant

## Regulation 19: Directory of residents

The registered provider shall establish and maintain a directory of residents in the designated centre incorporating the regulatory required information.

Judgment: Compliant

## Regulation 23: Governance and management

The registered provider had ensured a clear governance structure was appointed to the centre with clear lines of accountability.

Whilst monitoring systems were in place these required review to ensure they were effective in identifying all areas of concern and utilised to drive service improvement.

Judgment: Not compliant

## Regulation 3: Statement of purpose

The registered provider had prepared in writing a statement of purpose containing the information set out in Schedule 1. Clarification was required with respect to the staffing levels allocated to the centre.

Judgment: Substantially compliant

## Regulation 31: Notification of incidents

The inspector was satisfied that notifications were submitted to the chief inspector of social services as required.

Judgment: Compliant

## Regulation 34: Complaints procedure

The registered provider had provided a complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure. Improvements were required at centre level to ensure adherence to these procedures.

Judgment: Substantially compliant

## Regulation 4: Written policies and procedures

The registered provider had ensured the development of the policies and procedures as set out under schedule 5 of the Health Act. However, a number of these had not been reviewed within a three year period.

Judgment: Substantially compliant

## Quality and safety

The inspector reviewed the quality and safety of the service afforded to residents currently residing in Ardeevin. Interactions were observed to be professional in nature. Residents were protected from abusive situations and spoke very clearly of their needs. However, improvements were required to ensure that the centre was operated in a manner that facilitated choice of activities and interests for all.

The inspector found that the centre was not operated in a manner which promoted the residents choice of activities. On the day of inspection a number of residents were observed spending long periods of time sleeping in the living room, or listening to music. Staff partook in a number of household duties at this time such as preparing meals and tending to laundry. Residents were observed requesting activity however, due to the practices within the centre this was not always facilitated. Daily planners set out, were not adhered to with activities set out not accommodated such as hand massages.

Whilst the person in charge had ensured the development of an individualised personal plan these required review. Weekly planners were in place for some residents however, these had not been reviewed since the commencement of the current pandemic. Personal goals were not in place consistently and where present evidence of progression was not in place, for example one residents goals was to participate in the local community, within records this had only occurred on five occasions since July 2020. Whilst the provider was actively engaging to ensure all staff were trained in the development of personal goals through social role valorisation some residents did not appear to have goals since the centre became operational in 2018.

The registered provider had ensured the development of a risk management policy. This incorporated the regulatory required risks. The person in charge had implemented some measures to ensure the effective assessment, management and ongoing review of risk. A risk register had been developed and reviewed as required to ensure control measures were effective. However, a number of risks had not been identified within this register. For example, staff lone working during day time hours and staff leaving the main house to attend to the laundry external to the property.

Overall, the registered provider had ensured that effective fire safety management systems are in place. All firefighting equipment present was regularly serviced by a competent person. Staff completed regular checks on all equipment and access and egress points. However, evacuation drills were not completed in a consistent manner to ensure awareness of evacuation procedures for all residents and staff. The centre specific evacuation plan also required review to ensure this provided

guidance with regard to all situations. For example this set out the evacuation of residents during the day with three staff present. This staffing level was not always in place.

The registered provider had ensured that residents, staff and visitors were protected from infectious disease by adopting procedures consistent with the standards for the prevention and control of health care associated infections published by the Authority and adhered to current national guidance. An organisational contingency plan was in place which addressed COVID 19 through such areas as staffing, PPE and staff training. Staff were observed adhering to these guidelines throughout the inspection.

## Regulation 13: General welfare and development

The inspector found that the centre was not operated in a manner which promoted the residents choice of activities. On the day of inspection a number of residents were observed spending long periods of times sleeping in the living room, or listening to music.

Judgment: Not compliant

## Regulation 17: Premises

The design and layout of the centre met the objectives and function as set out in the statement of purpose. The residents were supported with the decoration and maintenance of their home.

The centre was clean and well presented with accessibility facilitated throughout.

Judgment: Compliant

## Regulation 26: Risk management procedures

The registered provider had ensured the development of a risk management policy. This incorporated the regulatory required risks. The person in charge had implemented some measures to ensure the effective assessment, management and ongoing review of risk. Improvements were required to ensure that all areas of risk were identified and addressed accordingly.

Judgment: Substantially compliant

## Regulation 27: Protection against infection

The registered provider had ensured that residents, staff and visitors were protected from infectious disease by adopting procedures consistent with the standards for the prevention and control of health care associated infections published by the Authority and adhered to current national guidance.

Judgment: Compliant

## Regulation 28: Fire precautions

Overall, the registered provider had ensured that effective fire safety management systems are in place. However, evacuation drills were not completed in a consistent manner to ensure awareness of evacuation procedures for all residents and staff.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and personal plan

Each resident had a comprehensive and individualised personal plan in place. The personal plans provided guidance for staff on the multi-disciplinary support needs of residents in a clear concise manner. However, personal goals had not been consistently set following consultation with the resident, documentation of any progression of goals required review.

Judgment: Not compliant

## Regulation 8: Protection

The registered provider had ensured that each resident was assisted to protect themselves from abuse. Where a safeguarding concern was identified, measures were implemented to protect the individual from all forms of abuse.

The personal and intimate care needs of all residents was laid out in personal plan in a dignified and respectful manner

Judgment: Compliant

## Regulation 9: Residents' rights

The designated centre was operated in a manner that was respectful of all residents valuing their individualism. Residents were consulted in the day to day operations of the centre and consulted on all aspects of their support needs. However, improvements were required to ensure choice was facilitated at all times.

Judgment: Substantially 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** | |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Not compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 19: Directory of residents | Compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 3: Statement of purpose | Substantially compliant |
| Regulation 31: Notification of incidents | Compliant |
| Regulation 34: Complaints procedure | Substantially compliant |
| Regulation 4: Written policies and procedures | Substantially compliant |
| **Quality and safety** | |
| Regulation 13: General welfare and development | Not compliant |
| Regulation 17: Premises | Compliant |
| Regulation 26: Risk management procedures | Substantially compliant |
| Regulation 27: Protection against infection | Compliant |
| Regulation 28: Fire precautions | Substantially compliant |
| Regulation 5: Individual assessment and personal plan | Not compliant |
| Regulation 8: Protection | Compliant |
| Regulation 9: Residents' rights | Substantially compliant |

# Compliance Plan for Ardeevin OSV-0005777

## Inspection ID: MON-0030176

## Date of inspection: 07/10/2020

**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:<br>The PIC and PPIM have met on the 15/10/2020 to complete an Action Learning Analysis to ensure review and learning from the inspection. Following areas were discussed in relation to staffing:<br><br>• Staffing levels were reviewed with the PPIM to ensure the PIC, who is responsible for three designated centres is supernumerary in her role to ensure her PIC duties are completed and sufficient staffing levels available to the people supported in Ardeevin as outlined in the Statement of Purpose.<br>• Agency staffing requests were approved to ensure safe staffing levels until vacancies are re-filled.<br>• Daily plans and shift planners were reviewed by the PIC to ensure person supported's daily routines and preferences are facilitated and safe practices adhered to.<br>• Daily plans and shift planners were discussed with the staff team at the team meeting on the 05/11/2020.<br><br>Staff recruitment process was successful and a new staff member has commence work in Ardeevin on the 16/11/2020. | |
| Regulation 23: Governance and management | Not Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>To ensure the clear governance and management structure the PIC and PPIM have completed an Action Learning Analysis on the 15/10/2020 to identify all areas of learning | |

for the PIC.

The PIC is responsible in her role for 3 designated centres, is in full time employment and supernumerary in her role to ensure adequate time for her PIC duties. The PIC is supported by the PPIM through monthly Quality Conversations. Areas of concern or improvement are discussed and actions followed through.

To support learning for other PICs in SPC the PIC will be presented learning and outcomes of the Action Learning Analysis at the Quality Assurance meeting on the 24/11/2020 with following areas to be discussed:
• Responsibilities within Governance and Management of a designated centre
• Impact of unsuitable staffing levels on the fulfillment of roles
• Impact on quality of life for people supported
• Need of risk management
• Solutions as a result of the Action Learning Analysis

The PIC has also reviewed the outcomes of the 6 monthly unannounced visit in light of the feedback of recent HIQA inspection and risk assessed the possible impact on people supported with not sufficient staffing levels.

Feedback in regards to the new 6 monthly unannounced visits completed in SPC has been discussed with the auditors on the 18/11/2020 to ensure further building of competence within the auditing team.
Quality Department has developed a feedback form for all annual and 6 monthly unannounced visits, which can now be used by PICs to give feedback and highlight also factual inaccuracies of completed audits.

A full review of SPC audit and checklist schedule is currently underway within SPC departments. As part of the review of SPC policies and pathways a new approach regarding auditing systems is being discussed to ensure a more person centred and house specific approach regarding audits as a management tool.

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| Regulation 3: Statement of purpose | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
A review of staffing levels has been completed since the inspection took place. The Statement of Purpose is now reflecting the correct staffing levels in place in Ardeevin.

| Regulation 34: Complaints procedure | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The HIQA inspector identified on the day of the inspection that a complaint was closed off but this had not been documented on the complaints log. The PIC has now ensured that the closure of the complaint is evident on the house specific log and an old complaints policy has been removed from the house folder.

The PIC has planned a meeting with the complaints officer before 20/12/2020 to ensure a better understanding of the complaints policy and procedure, which will be discussed at the next team meeting.

| Regulation 4: Written policies and procedures | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
To ensure a comprehensive review of all Schedule 5 policies a SPC policy working group has commence in April 2020. An update on progression of finalising the outstanding policies will be discussed at the next meeting on the 24/11/2020.

Finance Department and Quality have reviewed the SPC finance pathway and a new policy on managing people's money and property is currently being developed, which also includes a new system around person supported's finances and the auditing process.

Operations and Training department have scheduled a meeting for 24/11/2020 to discuss further development of training supports and reporting system, which will lead to the development of the new SPC staff training and development policy.

Quality Department will keep the inspector updated on progression of Schedule 5 policies.

| Regulation 13: General welfare and development | Not Compliant |
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Outline how you are going to come into compliance with Regulation 13: General welfare and development:

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| Staffing levels in Ardeevin have been reviewed to ensure people are supported by 2 to 3 staff members as outlined in the Statement of Purpose.<br>To ensure that people living in Ardeevin are supported in line with their wishes and choices the PIC has discussed choice making with the staff team at the team meeting on 5/11/2020 based on the HIQA inspection report.<br>Staff team are supported by their PIC to review the timetables for each person on a daily basis to suit each person's needs and wishes in line with their personal plan. |

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| Regulation 26: Risk management procedures | Substantially Compliant |

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| Outline how you are going to come into compliance with Regulation 26: Risk management procedures:<br>Since the inspection took place the PIC has developed a risk assessment for lone working which has been discussed with the staff team. The PIC has highlighted in the discussion with the team the impact reduced staffing levels can have on the quality of life for the people supported. |

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| Regulation 28: Fire precautions | Substantially Compliant |

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| Outline how you are going to come into compliance with Regulation 28: Fire precautions:<br>To build capacity within the staff team around fire evacuation the PIC and team have scheduled fire drills since 27/10/2020. This will ensure that all staff members are involved in the evacuation process for the people supported in Ardeevin.<br>PEEPs and CEEP have been reviewed and discussed at the team meeting on the 5/11/2020. |

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| Regulation 5: Individual assessment and personal plan | Not Compliant |

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| Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:<br>The PIC completed a review of personal plans in Ardeevin since the inspection took place. Each person had received a review of their visioning, which were completed by |

28.07.2020 and available on file.

Implementation of the new Personal Plan Framework is ongoing in Ardeevin for all people supported. The assessment process has been started and annual reviews as part of the new system are taking place since the 10/11/2020. All annual reviews will be completed by the 30/11/2020, including their previous visioning meeting minutes. Monthly review meetings are then completed for each person to ensure evidence of progression on roles and goals.

The PIC will be attending QA meeting on the 24/11/2020 where further supports and feedback will be provided to build capacity on PIC level in the implementation of person centred planning and the evidence of progression of roles and goals.

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| Regulation 9: Residents' rights | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The PIC and staff team have reviewed the shift planners in Ardeevin since the inspection took place to reflect each person's choices for activities and progression of roles and goals.
Areas of active supports as part of each person's planning and visioning meetings were discussed to ensure a better understanding within the team of how person's daily supports shall be facilitated.

Weekly residents meetings are implemented in Ardeevin. As part of reviewing the quality of the residents meetings the PIC has identified the need of improving the quality of residents meetings in regards to supporting the team in their reflection on facilitating the meetings and to improve their ability in listening to the people supported.

## 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)(a) | The registered provider shall provide the following for residents; access to facilities for occupation and recreation. | Not Compliant | Orange | 05/11/2020 |
| 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. | Not Compliant | Orange | 05/11/2020 |
| Regulation 13(2)(c) | The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community | Not Compliant | Orange | 05/11/2020 |

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| | in accordance with their wishes. | | | |
| 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 | 15/10/2020 |
| 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. | Not Compliant | Orange | 18/11/2020 |
| 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 | 05/11/2020 |
| Regulation 28(3)(d) | The registered provider shall make adequate arrangements for | Substantially Compliant | Yellow | 05/11/2020 |

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| | evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations. | | | |
| Regulation 28(4)(b) | The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire. | Substantially Compliant | Yellow | 05/11/2020 |
| Regulation 03(1) | The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1. | Substantially Compliant | Yellow | 15/10/2020 |
| Regulation 34(1)(d) | The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre. | Substantially Compliant | Yellow | 20/10/2020 |

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| Regulation 04(3) | The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice. | Substantially Compliant | Yellow | 20/12/2020 |
| Regulation 05(6)(b) | The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability. | Not Compliant | Orange | 30/11/2020 |
| Regulation 05(6)(c) | The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more | Not Compliant | Orange | 30/11/2020 |

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| | frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan. | | | |
| Regulation 05(6)(d) | The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments. | Not Compliant | Orange | 30/11/2020 |
| Regulation 09(2)(b) | The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life. | Substantially Compliant | Yellow | 30/11/2020 |