Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of designated centre:	Sallynoggin
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Co. Dublin
Type of inspection:	Announced
Date of inspection:	11 July 2018
Centre ID:	OSV-0002890
Fieldwork ID:	MON-0021732

About the designated centre

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

The designated centre is comprised of three individual units located in a suburban South County Dublin area. One unit is a detached two storey house which is currently home to four residents, a second unit is semi-detached two storey house which is home to four residents, and the third unit is also a semi-detached two storey house which is home to four residents. At the time of inspection there was one vacancy in the centre. There is a person in charge appointed to manage the centre who has responsibilities for other services areas and who is supported in the role by a full-time supervisor. The centre provides 24 hour residential supports to individuals with varying levels of intellectual disabilities and has a core focus of promoting independence, privacy, dignity and respect.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
11 July 2018	08:20hrs to 19:15hrs	Thomas Hogan	Lead
11 July 2018	08:20hrs to 19:15hrs	Paul McDermott	Support

Views of people who use the service

The inspectors met and spoke with nine residents availing of the services of the designated centre. Residents communicated a high level of satisfaction with the service they received and were complimentary of the staff and management teams. Residents spoken with stated that they felt safe and secure and were confident that they could make a complaint if they needed to. There was clear evidence of a person centred approached and residents communicated the positive impacts of such measures on their daily lives. Residents were encouraged and supported to live as independent lives as possible and to engage in meaningful social roles in their local community. In addition to speaking to residents, the inspectors received 14 completed questionnaires which looked at areas such as satisfaction with the service, accommodation, food and mealtime experience, visitation arrangements, resident rights, activities, care and support, staffing, and complaints. Six of the questionnaires were completed by residents, five were completed by residents with the support of a staff member, one was completed by a staff member on behalf of a resident, and two were completed by a relative or friend on behalf of a resident. Strong themes of satisfaction with the services provided emerged from a review of the questionnaires completed.

Capacity and capability

The inspectors found that services delivered were safe and were of good quality. While areas for improvement were identified, overall, it was found that there were effective governance arrangements in place with clear lines of accountability. The necessary resources were in place to support the effective delivery of care and support to residents. Seven regulations were inspected relating to *capacity and capability.*

A review of staffing arrangements found that there were sufficient numbers of staff with the necessary experience and competencies to meet the needs of residents. Staff members were observed to interact with residents in a kind and respectful manner throughout the inspection period and residents spoke warmly of staff members to the inspectors. Staff duty rosters were reviewed and it was found that planned and actual rosters were not maintained; the name of the centre and units were not labelled on the documents; and not all staff members employed in the centre were listed. While there was no use of agency staff, a relief panel supported a core staff team and total relief hours were calculated to average at 162.5 hours per month over the first six months of 2018. The inspectors reviewed a sample of four staff files and found that there were gaps in employment histories in the case

of three of the four files and references were not complete in two cases.

Staff training and development records were reviewed by the inspectors and it was found that mandatory training was completed by all members of the staff team with the exception of 'break away techniques' training which six staff members had failed to complete. Staff members spoken with stated that training was beneficial, however, described that it was difficult to secure training in non-mandatory areas such as diabetes or epilepsy. There were arrangements in place for both the formal and informal supervision of staff members. Formal supervision was supported through an organisational policy on this matter and occurred through one-to-one meetings on at least six occasions annually. Informal supervision took the form of day-to-day presence of a supervisor or person in charge in the centre, the completion of clinical appraisals, and team meeting. Staff members spoken with stated that they felt supported in their roles and communicated that the person in charge and supervisor were approachable.

The inspectors found the the governance and management arrangements in place in the centre were positive and provided oversight in ensuring service delivery was safe and of a high quality. Despite this, areas for improvement were identified such as strengthening the quality of unannounced visits to the centre by the registered provider or persons nominated on their behalf. In addition, the area of fire safety was identified by the inspectors as one of concern and had not been previously been considered as such by the registered provider. Residents spoken with by the inspectors were able to identify both the person in charge and supporting supervisor and staff members spoken with stated that the management team were accessible and supportive.

A sample of four written contracts for the provision of services were reviewed by the inspectors and it was found that services to be provided were not comprehensively outlined. Services referred to in the agreements were limited to transport; meals and nutrition; healthcare and medication; and assessment and care planning.

A statement of purpose (dated May 2018) was reviewed by the inspectors. It was found that several areas of the document did not comply with the regulatory requirements and feedback was provided to the person in charge and registered provider on this matter. An opportunity to revise and update this document following this feedback was provided and a revised statement of purpose was submitted to the inspectors following the inspection. The revised statement of purpose (dated July 2018) was reviewed and found to contain three areas of non-compliance. These areas related to details of the specific care and support needs that the centre is intended to meet; details of separate facilities for day care; and details of fire precautions and emergency procedures in place in the centre.

The inspectors found that systems in place for managing complaints were not satisfactory. A comprehensive log or register of all complaints was not maintained locally and as a result, the management team were unable to verify the total numbers of complaints made in a given period and the statuses of individual complaints made. Despite this, residents spoken with were knowledgeable on how to make a complaint if required and there were accessible and easy read versions of

the organisational complaints policy and procedures available for residents. Staff members spoken with stated that complaints were managed well and that residents and family members were regularly informed of the complaints process and encouraged to make a complaint if appropriate.

Regulation 15: Staffing

A review of four staff files found that three contained gaps in the employment history of the staff members, and in two cases references were found not to be signed by the referees. The inspector found that maintenance of staff duty rosters required improvement. Planned and actual rosters were not maintained, rosters did not name the centre of the unit to which they related, and not all staff members employed were listed on the rosters.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The inspector found upon review of staff training records that six staff members had not completed training or refresher training in the mandatory training area of break away techniques.

Judgment: Substantially compliant

Regulation 22: Insurance

There was a policy of insurance which insured against injury to residents.

Judgment: Compliant

Regulation 23: Governance and management

While the inspector found evidence of good oversight of the designated centre, reports of unannounced visits to the centre by the registered provider or persons on their behalf indicated that not all areas of the centre were visited on these occasions.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The inspector found that services to be provided to residents were not comprehensively outlined in the written agreements between residents and the registered provider.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

A revised statement of purpose was submitted to the inspector post inspection and this version was reviewed and found to contain three areas which were in non-compliance with the regulations.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The inspector found that a register of complaints was not maintained in line with the organisational policy on this matter. As a result, the management team were not aware in some cases of the individual status of complaints made.

Judgment: Not compliant

Quality and safety

The inspectors found that residents were supported to make choices and were actively involved in shaping the service they were in receipt of; were supported to develop and maintain personal relationships and links with the local community; and were protected from harm or abuse. Six regulations were inspected against relating to *quality and safety.* Areas for significant improvement were identified in risk management and in medication management, while significant concerns were identified in the area of fire management.

A full walk through of all areas of the centre was completed by the inspectors in the company of the person in charge. It was found that the centre was homely and tastefully decorated in line with the wishes of residents. The centre was clean throughout, appeared to be well maintained, and was accessible to residents

availing of its services. There were enough bathrooms, toilets and showering facilities to meet the needs of residents and rooms appeared to be of a suitable size.

Risk management systems were found not to be satisfactory. The inspectors found that identified risks were not appropriately assessed by the registered provider and in some instances not all obvious risks had been assessed. While there was a risk register in place (dated June 2018) it lacked sufficient detail such as control measures. Despite this, having reviewed incident, accident and near miss records for a seven month period, the inspectors found that systems in place to manage and respond to such matters were satisfactory. A review of the organisational policy on risk management (dated 22 June 2018) found that two areas outlined in the regulations as required in the policy were not included. These were: the arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents; and the arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.

The inspectors found fire precaution and containment measures were not satisfactory. Personal emergency evacuation plans for residents were not reflective of needs identified during fire drills and did not outline the supports required by residents to evacuate in the event of a fire or emergency. Emergency lighting was not in place in all required areas of the centre. The fire detection and alarm system and emergency lighting were found not to have been serviced or maintained in a 10 month period in one unit of the centre. Fire containment measures were found to have been inconsistently applied across the centre with no measures in place in some areas. There was no protection for central stairwell areas in all three units despite these areas forming essential emergency exit routes. In addition, there were no seals on some internal doors, no self-closing mechanisms on doors, some fire doors which were in place were found not to be closing, and in one instance there was no break glass unit in place with keys for an emergency fire exit which was locked. Procedures to be followed in the event of a fire were not displayed in all units and where they were displayed were not in an easy read format. In addition, the inspectors found that appropriate actions had not been taken in response to identified needs of a resident who refused to evacuate the centre during a recent fire drill. An immediate action was issued to the registered provider regarding the non-compliances identified relating to fire safety at the time of inspection.

A review of medication management arrangements in place found that medication was not safely stored at the time of inspection. Keys for the medication cabinet were noted to be openly stored adjacent the cabinet. In the absence of expiry dates being listed on all medications, a staff member spoken with was unable to provide assurances that all appropriate checks were completed before the administration of medications. In addition, the inspectors found that all medications were not appropriately labelled. Systems for the appropriate storage of out-of-date or discontinued medications were not in place at the time of inspection. Medication which was out-of-date since 04 June 2018 was found to be stored in the main medication cabinet and had not been disposed of in line with organisational policy on this matter. A review of prescriptions for PRN medication (medication taken as

the need arises) found that ambiguity existed with regards to the maximum dose of medications that could be administered in a 24 hour period and the time to be taken between administrations. The inspectors found that capacity assessments had been completed for all residents with regards to the self-administration of medication.

The inspectors found that residents were supported to achieve and maintain the best possible health. There was timely access to medical professionals through primary care and specialist services. There were a wide variety of allied health professional services available within the organisation to support residents' needs including psychology, social work, psychiatry, occupational therapy, speech and language therapy, physiotherapy and nursing. In addition residents were found to be supported externally by general practice, dietetics, dental and chiropody services.

A review of incident, accident and near miss records found that four allegedly abusive peer to peer interaction occurred in a sampled time period of six months. The inspectors found that in all four cases appropriate follow up and response had taken place. Overall residents were safe while availing of the services of the centre. Staff spoken with demonstrated clear awareness of a 'zero tolerance' approach to the protection of residents and were knowledgeable of the actions to take in response to an allegation or suspicion of abuse. Residents spoken with by the inspectors stated they felt safe and were knowledgeable of how to report a concern if they had one.

Regulation 17: Premises

The inspector found that all three units of the designated centre were clean, suitably decorated and appeared to be in a good state of repair both internally and externally.

Judgment: Compliant

Regulation 26: Risk management procedures

A review of the risk management policy found that two pieces of information identified as being required in the policy document by the regulations were not included. In addition, risk management systems were found not to appropriately identify and assess all presenting risks.

Judgment: Not compliant

Regulation 28: Fire precautions

The inspectors found that fire containment measures were inconsistent in nature across the three units of the designated centre. Stairwells were not protected spaces despite forming a key escape route for evacuation. Both a fire detection and alarm system and emergency lighting was found not to have been serviced in a 10 month period in one unit. Emergency lighting was not present in all required areas. In one instance there was no break glass unit present with a key for an emergency exit door. Residents' personal emergency evacuation plans did not reflect needs identified through fire drill completion and the supports required by residents to evacuate were not clear.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

A review of medication storage arrangements found that medications were not stored securely. Systems in place for the storage and disposal of discontinued or out-of-date medication were found not to be satisfactory. Expiry dates were not listed on all medications and there was ambiguity with regards to the maximum dose that could be administered in the case of PRN medication.

Judgment: Not compliant

Regulation 6: Health care

The inspector found that residents had timely access to medical professionals and staff members spoken with demonstrated sufficient knowledge of the healthcare needs of residents.

Judgment: Compliant

Regulation 8: Protection

The inspector found that incidents of alleged abuse were appropriate managed and followed up on. Residents spoken with stated that they felt safe and staff members demonstrated appropriate knowledge of the action to take in the event of witnessing or suspecting the abuse of a resident.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Sallynoggin OSV-0002890

Inspection ID: MON-0021732

Date of inspection: 11/07/2018

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Reg 15(4). Staffs with 0.5 contracts are now listed separately on the Rota. The Titles of SCL and PIC have been replaced on Rota with actual staff names. Planned and actual rosters have been reviewed and the name of the Centre, OSV no. and the unit name will be visible on all Rota documentation. All staff, including those on leave, will be listed on the Rota. Legends will be inserted to explain abbreviations used (e.g. o/n = overnight) Reg 15(5) HR have been contacted in order to address anomalies found in staff files with regard to gaps in employment history and references unsigned by the referees.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Reg 16 (1) (a) Staff Training records have been reviewed and staff have been scheduled to attend any outstanding training. Reg 16 (1) (b) All Relief Staff have been assigned to specific Supervisors to ensure that accurate records are available. 4 of the staff identified as requiring Training in Break Away Techniques (MAPA) have now completed this training and training has been scheduled for the other 2 staff.	
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: Reg 23 (2) The next unannounced inspection by the persons appointed by the Registered Provider is due on or before 31.01.2019. Feedback from this HIQA Inspection report will be discussed with them in advance in order to strengthen the quality of these unannounced visits and ensure that each area of the D.C is included in their visit.	
Regulation 24: Admissions and contract for the provision of services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services: Reg 24(4)(a)The Contract of Care will be reviewed for each Resident (using the new template provided by the Quality & Safety division). The outline of services will be expanded to comprehensively outline all services available and costs that may be incurred by the resident.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: Reg 3(1) The Statement of Purpose has been updated to include additional information on the following • Details of the specific care and support needs that the centre is intended to meet • Details of separate facilities for Day Care. • Details of Fire precautions and Emergency procedures in place.	
Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: Reg 34 (1) The system for managing complaints will be reviewed in line with the SJOG organisational Policy. Reg 34(2)(b) The Management Team will be advised on a Monthly basis of the status of each complaint. Reg 34 (2) (f)The Complaints Log will be amended to clearly show the status of each complaint. This Log will be maintained in the D.C	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures:	

Reg 26 (1) (a) The Risk Management Policy to be amended to reflect that Fire is identified as our biggest area of concern. The two areas outlined in the report will now be included in the Policy.

Reg 26 (1) (e) The Control Measures outlined in the Risk Register have been reviewed in order to be proportional to the risk identified.
Reg 26 (2)
Risks highlighted by the HIQA Inspection were discussed with the Fire Safety Expert engaged by the Service Provider in order to assess and review those risks accurately.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Reg 28 (1). The Registered Provider commissioned a Fire Safety expert to complete a report in July 2018. Recommendations from this report were actioned in 97 Glenageary Ave in August 2018 and are scheduled for action in Kilgarvan and 98 Glenageary Ave .
Reg 28 (2)(a) Fire precaution and containment measures have been improved by the insertion of Fire doors in one location of the D.C to date. The other 2 areas are scheduled for this work to be carried out.
Reg 28 (2)(b)(i) The work of the company maintaining the fire system has been reviewed in terms of the service and maintenance.
Reg 28(2)(b)(ii) Fire precautions were reviewed by the Fire Safety expert and discussed with the Supervisor and an action plan devised.
Reg 28(2)(b)(iii) The testing of the Fire Systems will be reviewed with the Health & Safety Coordinator and Maintenance Manager
Reg 28(2)(c) Emergency lighting was installed in 97 Glenageary Ave .as per Fire Officers recommendations from his July 2018 report. 98 Glenageary Ave and Kilgarvan are scheduled for this work.

Reg 28(3)(d) The support of the MDT has been sought to successfully assist the team to evacuate the identified resident during recent drills.
Reg 28(4)(a) Identified support needs of residents will be reflected in their PEEP's

Reg 28(4)(b) All staff will be scheduled to partake in a drill. The PEEPs for all Residents were reviewed with particular attention to the individual highlighted during the Inspection.

Reg 28(5) A local Fire Protocol has been developed. Information of procedures to be followed in the event of a fire has been placed in a prominent place in the hallway of each house for staff and residents. Other distracting material displayed has been removed.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Reg 29(4)(a) New Locked Key storage presses have been installed in all 3 locations.

Reg 29(4)(c).Arrangements for the return of out of date products agreed with Pharma logical Supplier in order to improve our current practice which had out of date medication stored in a separate box in the locked medicine press.

Error noted re Labelling on day of inspection was investigated and reviewed.
to ensure expiry dates is visible on all medication used.
New arrangements have been made with the Pharmalogical supplier to ensure that Out of Date dates are clearly visible on all medication.
The pharmacy have added a statement to the identification of medications in the blister pack to state that all medications are valid until the date on the final blister.
This has improved our ability to perform accurate Checks on the receipt of the medication.

The max dosage for PRN medications has been amended and clarified on all Cardexs

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(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	01/10/2018
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	01/10/2018
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.	Substantially Compliant	Yellow	30/11/2018
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of	Substantially Compliant	Yellow	31/01/2019

	care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Substantially Compliant	Yellow	21/12/2018
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Not Compliant	Orange	31/10/2018
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Not Compliant	Orange	31/10/2018
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.	Not Compliant	Orange	19/11/2018
Regulation 28(1)	The registered provider shall ensure that effective fire	Not Compliant	Red	29/03/2019

	safety management systems are in place.			
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Red	29/03/2019
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Red	29/03/2019
Regulation 28(2)(b)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Not Compliant	Red	29/03/2019
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Red	29/03/2019
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	29/03/2019
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Red	02/10/2018
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.	Not Compliant	Orange	28/09/2018
Regulation 28(5)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place and/or are	Not Compliant	Orange	15/07/2018

	readily available as appropriate in the designated centre.			
Regulation 29(4)(a)	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 any medicine that is kept in the designated centre is stored securely.	Not Compliant	Orange	20/09/2018
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	20/09/2018
Regulation 29(4)(c)	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 out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.	Not Compliant	Orange	20/09/2018
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information	Substantially Compliant	Yellow	02/10/2018

	set out in Schedule 1.			
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	02/10/2018
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Not Compliant	Orange	14/10/2018