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

Name of designated centre:	Community Houses Dundrum
Name of provider:	Health Service Executive
Address of centre:	Dublin 16
Type of inspection:	Announced
Date of inspection:	31 October 2018
Centre ID:	OSV-0004647
Fieldwork ID:	MON-0023256

About the designated centre

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

The designated centre is based in a suburban area of South Dublin and is comprised of two units. One, a semi-detached house, is home to three residents, while the second unit, also a semi-detached house, is home to four residents. Services provided from the centre include 24 hour residential supports and residents are supported through nursing and health care assistant teams. There are a wide variety of services and amenities available within short reach from both units including shops, post offices, medical centres, and access to public transport.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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
31 October 2018	10:00hrs to 18:00hrs	Thomas Hogan	Lead
31 October 2018	10:00hrs to 18:00hrs	Michelle McDonnell	Support

Views of people who use the service

The inspectors met with four residents availing of the services of the designated centre at the time of the inspection. Overall, it was found that residents were very satisfied with the services they were in receipt of and were complimentary of the staff and management team. When asked, residents communicated that they felt safe in the centre and were aware of how to express any concerns that they may have. Six completed questionnaires were returned to the inspectors and overall it was found that similar to discussions held with residents, there were high levels of satisfaction identified. The questionnaires asked respondents for their views on areas such as accommodation, food and mealtime experience, arrangements for visitors, rights of visitors, activities, care and supports, staffing, and complaints. Respondents who completed the questionnaires included residents, staff members assisting residents, and family members. Some themes emerging from a review of questionnaires and discussions held with residents included requirements for improvement in the areas of provision of familiar or a consistent staff team, availability of transport vehicles, management of personal finances, menu planning and availability of foods and snacks outside of mealtimes, and participation in the wider community.

Capacity and capability

The inspectors found that overall, the centre was delivering safe services of a good standard to residents. There were effective governance structures in place with clear lines of accountability. There was evidence available which clearly demonstrated that residents availing of the services of the centre were central to decisions made by the management team. Some regulations were identified as requiring improvement including ensuring a consistent staff team were in place in the centre, minor deficits in staff mandatory training, the absence of performance management of the staff team, and a policy document requiring review.

A review of staffing and duty rosters in place in the centre found that there were sufficient resources allocated to the service area, however, minimum staffing numbers were not in place at all times. There was evidence of reliance on agency staff to supplement the core staffing team, and while there was an awareness of the importance of ensuring familiar staff members were providing care and support to residents, this was not always the case. The person in charge outlined that a recruitment campaign was underway to ensure that this matter was resolved and provided assurances that it would be addressed in the coming months. Staff members were observed to interact with residents in a respectful and kind manner throughout the time of inspection. The inspectors met and spoke in detail with three staff members and found that they were very knowledgeable of the needs of residents. Staff duty rosters in place in the centre were found not to have been satisfactorily maintained. Staff duty rosters in place in the centre were found not to have been satisfactorily maintained. Planned and actual rosters were not maintained

in the centre and rosters which were in place did not include job titles of all staff members and the starting and finishing times of work shifts.

The inspectors reviewed staff training records and found that all staff members had completed all mandatory training with the exception of one staff member who had not completed training in the area of managing behaviours which are challenging. There were satisfactory arrangements in place for both the formal and informal supervision of staff members employed in the centre. There was evidence of regular one-to-one supervisory meetings being held with a number of staff members who's supervision records were sampled by the inspectors. Staff members spoken with by the inspectors communicated that they felt supported in their roles and could contact their line manager for advice or direction when required. There was an out-of-hours on call support service in operation in the centre where a senior manager was available to support staff members in the event of it being required during evening, night time or weekend periods.

The inspectors found when reviewing governance and management arrangements that there were appropriate systems in place to ensure service delivery was of a high standard. A management team, which supported the person in charge in the operation of this centre and two others, had a considerable presence in each of the units and ensured appropriate oversight of service delivery. There had been a suite of service audits completed which included scheduled visits, food safety, quality and safety, environmental cleanliness, and medication management. In addition, the inspectors found that annual reviews and six monthly unannounced visits to the centre had been completed in line with regulatory requirements. There were some resource issues identified at the time of inspection which included an absence of access to information and communications technology in individual units of the centre. In addition, the inspectors found that there were no arrangements in place for the performance management of the staff team. The person in charge was found to be very knowledgeable of their responsibilities, regulations and legislation. Throughout the period of inspection the person in charge demonstrated a very proactive approach to the findings of the inspectors and addressed minor shortcomings on the day of inspection.

A review of admissions, discharges and transfers to and from the centre found that there had been none since the time of the last inspection. The inspectors were satisfied that there were appropriate systems in place to ensure that all residents were protected in the even of an admission, discharge or transfer in the future. Residents were found to have written contracts of care in place which outlined the services to be provided by the registered provider. All contracts sampled by the inspectors were found to have been singed by residents, or persons on their behalf, and a representative of the registered provider.

The registered provider was found to have all required Schedule 5 written policies and procedures in place and available in the centre. All of the policies with the exception of one were found to have been reviewed and updated at three yearly intervals. The policy in place relating to the creation of, access to, retention of, maintenance of and destruction of records had not been reviewed and updated as

required in this time frame.

A statement of purpose (dated July 2018) was in place in the centre and was reviewed by the inspectors. It was found that nine areas of this document did not fully comply with the requirements set out in Schedule 1 of the regulations. Feedback on this matter was provided to the person in charge and an opportunity to update and revise the document was provided. A revised statement of purpose (dated October 2018) was submitted to the inspectors after the inspection and was found to satisfactorily meet the requirements of the regulations.

Regulation 15: Staffing

Minimum staffing levels were not maintained at all times in the centre. Staff duty rosters in place in the centre were found not to have been satisfactorily maintained. Planned and actual rosters were not maintained in the centre and rosters which were in place did not include job titles of all staff members and the starting and finishing times of work shifts.

Judgment: Not compliant

Regulation 22: Insurance

There was evidence available to demonstrate that there was a contract in place which insured against injury to residents.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

All contracts sampled by the inspectors were found to have been singed by residents, or persons on their behalf, and a representative of the registered provider.

Judgment: Compliant

Regulation 3: Statement of purpose

A revised statement of purpose (dated October 2018) was submitted to the inspectors after the inspection and was found to satisfactorily meet the

requirements of the regulations.

Judgment: Compliant

Regulation 4: Written policies and procedures

The policy in place relating to the creation of, access to, retention of, maintenance of and destruction of records had not been reviewed and updated as required in a three year time frame.

Judgment: Substantially compliant

Regulation 16: Training and staff development

One staff member was found not to have completed one mandatory training course.

Judgment: Substantially compliant

Regulation 23: Governance and management

There were some resource issues identified at the time of inspection which included an absence of access to information and communications technology in individual units of the centre. In addition, the inspectors found that there were no arrangements in place for the performance management of the staff team.

Judgment: Substantially compliant

Quality and safety

The inspectors found, overall, that residents availing of the services were supported to live active lives and to develop and maintain valued social roles in their community. There was evidence available which demonstrated that there was a culture of person-centredness present in the designated centre which placed value on a high standard of service delivery. Residents were supported to exercise their rights and to achieve personal goals and aspirations. Overall, it was found while there were some mixed levels of compliance identified, the person in charge and management team were aware of shortcomings and had plans in place to ensure

these were addressed. Areas for improvement identified by the inspectors included fire safety, accessibility, medication management, and ensuring appropriate follow up to presentations of unexplained bruising.

A review of the general welfare and development of residents found that individuals were provided with appropriate care and supports in accordance with evidence-based practice. Residents were supported to develop and maintain natural networks in the local community. The inspectors met with a resident with a keen interest in knitting who had attended a local knitting club on the day of inspection. In addition, residents were found to have been supported to attend clubs and activities in areas such as mindfulness, aqua aerobics, bowling, zumba dancing and tai-chi. At least one resident had secured paid employment with the support of the staff team and was attending work on the day of inspection. Residents were supported to develop and maintain relationships with family members with an example provided to the inspectors by one resident who reconnected with a relative living overseas through the use of an electronic tablet and video call software. The resident was supported to develop the skills to use this technology through staff supports and it now plays a central part in their network of support. On the day of inspection one resident was observed to be planning a foreign holiday with staff members and arranging a meeting with other support persons to facilitate this.

The premises of the centre were found to be maintained to a high standard throughout both internally and externally. Both units were clean and suitably decorated and provided sufficient private and communal space to accommodate residents, staff members and visitors. In one unit of the centre the inspectors found that storage facilities were limited resulting in a ground floor toilet area being used to store items. In addition, this unit was found to have some minor non-compliances in the area of accessibility. The main entrance to the unit was found to contain steps which one resident had difficulty navigating to gain entry to the building.

The inspectors found that measures were in place in the centre for the containment of fire. Fire doors were installed in all necessary areas and had self-closing mechanisms attached which activated in the event of a fire. Attic doors in both units of the centre appeared not to have fire doors in place and there was an absence of evidence available to confirm this. While there were arrangements in place to service and maintain the fire alarm and detection systems and emergency lighting on a quarterly basis, this was found not to have occurred on four occasions in 2017. While there was some emergency lighting installed in the centre, the inspectors found that not all areas which required emergency lighting had this in place. For example, in both units emergency exit routes did not have this form of lighting in place to illuminate the path to the exit. Fire drills were found to have been completed on a regular basis and demonstrated that residents and staff evacuated the centre in appropriate time frames. The person in charge submitted information to the inspectors following the inspection which demonstrated that these areas of non-compliance were being addressed in an accelerated time frame. Staff members spoken with demonstrated appropriate knowledge of what to do in the event of a fire and stated that they were confident that all persons could be safely evacuated in the event of an emergency. There were personal emergency evacuation plans in place for each resident and these were found to satisfactorily inform the reader on

what individualised supports were required by each person in the event of an emergency.

A review of medication management arrangements found that medications were stored in an appropriate manner. A blister pack system was in use for regular medication and the person in charge was able to provide evidence which ensured that these medications were within their expiry dates. There was a PRN medication (medication only taken as the need arises) contained within the medication cabinet in one of the units of the centre which did not have an expiry date listed. Medication prescriptions and administration records were reviewed by the inspector and these were found to be satisfactorily maintained. Only one of seven residents availing of the service of the centre were found to have had risk and capacity assessments completed for the self-administration of medication. Staff members spoken with demonstrated satisfactory knowledge of what to do in the event of a medication error.

The inspectors found that residents availing of the services felt safe. There was a satisfactory awareness of what constituted abuse amongst the staff and management teams. A review of incident and accident records for the period of 2018 (up to the time of inspection) found that two peer to peer physical incidents which had occurred in the centre were appropriately investigated and followed up on. However, four unexplained bruising incidents reported were found to not have been managed in accordance with national policy or best practice in this areas. The person in charge outlined plans to the inspectors to address this matter and to ensure best practice going forward.

The rights of residents were observed to have been upheld and respected by the registered provider. There was evidence that a person-centred and resident-led service was in place. Residents participated in the operation of the centre through participation in resident meetings and advocacy forums. The inspectors observed that shopping lists for the centre had input from all residents to ensure that the individual and collective preferences of all were catered for. The privacy and dignity of residents was respected and each individual had single bedrooms. A charter of residents' rights was on display in the centre which informed readers of fundamental rights of residents availing of the services of the centre. There was a consent policy (June 2018) and a person-centred support policy (dated May 2017) also in place and informing local practice in this area.

Regulation 13: General welfare and development

The inspectors found that residents were provided with appropriate care and supports in accordance with evidence-based practice.

Judgment: Compliant

Regulation 17: Premises

In one unit of the centre the inspectors found that storage facilities were limited resulting in a ground floor toilet area being used to store items. In addition, this unit was found to have some minor non-compliances in the area of accessibility. The main entrance to the unit was found to contain steps which one resident had difficulty managing.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There was an absence of evidence to confirm that attic doors in place in the centre were fire doors. Emergency lighting was not in place in all required areas of the centre. The fire alarm and detection systems and existing emergency lighting was not serviced and maintained on a quarterly basis in 2017 as required by the registered provider.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

There was a PRN medication (medication only taken as the need arises) contained within the medication cabinet in one of the units of the centre which did not have an expiry date listed. Only one of seven residents availing of the service of the centre were found to have had risk and capacity assessments completed for the self-administration of medication.

Judgment: Substantially compliant

Regulation 8: Protection

Four unexplained bruising incidents reported were found to not have been managed in accordance with national policy or best practice in this areas.

Judgment: Substantially compliant

Regulation 9: Residents' rights
The rights of residents were observed to have been upheld and respected by the registered provider.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 22: Insurance	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Community Houses Dundrum OSV-0004647

Inspection ID: MON-0023256

Date of inspection: 31/10/2018

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	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
Staffing: The provider ensures that the number, qualifications and skill mix of staff are appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the centre. Nursing care is provided as required subject to the statement of purpose and the assessed needs of the residents. Staffing is allocated to ensure the residents receive of continuity of care and support from staff who are consistently assigned to the centre as far as is reasonably practicable. The use of regular consistent staff agency staff is utilised as per HSE Agency Framework due to the difficulty the organization is encountering in hiring nursing/health care personnel.

In response to the areas of non-compliance found under the regulations 15(1)
The Provider will:
• Continue to engage with National Recruitment Services around identifying both Nursing and Health Care Staff who are on Intellectual Disability National panels.
• Continue to run Local Campaigns around Dublin South/Kildare area.
• Establish links with Third Level Institutions to attract graduates of nursing and relevant FETAC (Intellectual Disability) courses for health care staff.
• Continue to work with the HSE Agency Framework and the identified agencies Disability Services (SSIDS) to run rolling competitions for both Nursing and Care Staff (intellectual Disability). Each competition can take approximately 6 months from interview to commencement of employment.
• Run a minimum of 3 recruitment campaigns (nursing and care staff) within the next 12 months (a recruitment campaign for care staff occurred on the 5th and 7th of November 2018).
• In Q1 of 2019 there will be a local SSIDS nursing and care staff recruitment campaign and a further nursing recruitment campaign in Q2 of 2019.

In response to the area of non-compliance found under Regulation 15(4)
The Person in Charge will:

• Ensure the planned and actual staff rota, identifies staff on duty during the day and night, amendments will be been made to the Roster Form to capture this. Completed
• Ensure that the rosters in place will include job titles of all staff members and the

starting and finishing times of work shifts. Completed	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: In response to the area of Substantial compliance found under Regulation 04 (3) the Provider will: • Ensure the HSE Policy in relation to the Creation of, Access to, Retention of, Maintenance of destruction of Records is reviewed and updated at intervals not exceeding 3 years and update the policy in accordance with best practice. Completed	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme. In response to the area of Substantially Compliant found under the regulations 16 (1) (a) Training will be arranged for staff to attend to ensure all training is up to date.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider will ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering. In Response to the area of Substantial Compliance found under regulation 23 (1)(a) The PIC will: • Arrange for the costing, roll out and establishment of computers for all houses in Dundrum Designated Centre. In Response to the area of Substantial Compliance found under regulation 23 (3)(a) The PIC will: • Ensure that professional development plans are supported by training and education programs. This will include a combination of Supervision and Performance Feedback meetings with staff members and their line manager. • Arrange for Supervisor Training. • Organize a schedule of in-house training that will include Dignity at Work and Legal Training Framework. • Work with the Policy Committee to review and amend Supervision Policy to reflect the need for Performance Feedback meetings.	

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The registered Provider, having regards to the needs of the residents of the designated centre, provide premises which confirm to matters set out in schedule 6

In response to the area of Substantially Compliant under Regulation 17 (6)
• The PIC will arrange for Primary Care Occupational Therapist to assess the main entrance to the house and follow up on recommendations made.

In response to the area of Substantially Compliant under Regulation 17(7)
• The PIC will arrange for a shed to be installed in order to increase the amount of storage space available within the house.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The Registered Provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

In response to the area of Substantially Compliant found under28(2)(b)(1)
The PIC will
• Contact the HSE fire prevention officer and have the attic doors inspected to confirm if they are fire doors. Following inspection the PIC will ensure all works recommended by Fire Officer will be carried out.

In response to the area of Not Compliant found under28(2)(c)
• The PIC will contact the HSE Fire Prevention Officer have arrange to have emergency lightening installed.

In response to the area of Substantially Compliant found under28(3)(a)
• The PIC will inform the Fire Prevention Officer that the servicing of fire alarms, fire detection systems and emergency lighting are to be carried out on a calendar 12 month period, not a rolling 12 month period in order to ensure quarterly inspections are carried out in a timely manner. Completed
• The PIC will include "last date of inspection of fire equipment and emergency lighting" to the weekly/monthly check list of scheduled unannounced visits by community team. Completed

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The Person in Charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storage, disposal and administration of medicines to ensure that medicine is administered as prescribed to the resident for whom it is prescribed and to no other resident.

In response to the area of Substantially Compliant found under29(4)(b) • The PIC will meet with pharmacy to ensure PRN medications have an expiry date on labels. Completed In response to the area of Substantially Compliant found under29(5) • The PIC will arrange for all residents to have a self-administration assessment carried out and risk assessments completed where appropriate. Completed

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
In response to the area of Substantially Compliant found under 08(3)
The PIC will:
• Review and update template for the recording of actions and outcomes of incidents to ensure the PIC Decision following investigation of incident is added to the form. Completed

Section 2: Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/06/2019
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.	Not Compliant	Orange	12/10/2018
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	31/12/2018
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Substantially Compliant	Yellow	28/02/2019

Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/12/2018
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	30/06/2018
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	31/03/2019
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.	Substantially Compliant	Yellow	20/12/2018
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	20/12/2018
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	12/10/2018
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	Substantially Compliant	Yellow	12/10/2019

	for whom it is prescribed and to no other resident.			
Regulation 29(5)	The person in charge shall ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability.	Substantially Compliant	Yellow	20/10/2018
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	31/12/2018
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Substantially Compliant	Yellow	20/11/2018