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:	Liosmor
Name of provider:	Brothers of Charity Services Ireland
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	09 October 2018
Centre ID:	OSV-0004745
Fieldwork ID:	MON-0020884

About the designated centre

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

This service is based in a purpose built premises located in a rural but populated area approximately ten minute drive from two busy towns; transport is provided. The centre can accommodate a maximum of nine residents and is designed and laid out to promote accessibility and the needs of residents with higher physical support needs. The provider aims to provide each resident with a safe, homely environment where they are to be provided with quality care and enjoy quality of life as appropriate to their individual needs and requirements. The centre is open and staffed on a full-time basis. The staff team is comprised of nursing and care assistant staff led by the person in charge and a clinical nurse manager 1(CNM1).

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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
09 October 2018	09:15hrs to 18:00hrs	Mary Moore	Lead

Views of people who use the service

On arrival at the centre staff and residents were attending to the normal morning routines; there was a relaxed atmosphere and easy pace; staff and residents welcomed the inspector. Residents spoke about their plans for the day and the staff that were to accompany them. Ongoing participation in the advocacy programme was discussed. Residents spoke of the loss of a fellow resident and showed the inspector the remembrance wall where deceased residents were remembered on a daily basis. Residents were clearly familiar with all of the staff on duty and with the very recently appointed person in charge. Residents looked well and presented throughout the day as relaxed and content in their home and with the staff on duty. Residents raised no concerns with the inspector and said that everything was good in the centre.

Capacity and capability

This inspection was undertaken to monitor the provider's management and oversight of this service and to provide assurance that the progress and improvement found by the inspection in September 2017 had been maintained. Overall the inspector found that it was, with positive impact noted on both the safety and quality of resident's lives. There were areas that required further improvement and these are discussed below and in the next section of the report.

The inspector found improved governance arrangements that supported consistent monitoring of the appropriateness, safety and quality of the service. The provider had put in place the enhanced management systems committed to in 2017. The person in charge was now responsible only for this centre, worked full-time and was supported by the CNM1. Both managers worked collaboratively so as to ensure a consistent management presence on site each day including weekends; they also met at least once a week to review, discuss and monitor the general operation of the centre.

The support and supervision of staff was discussed including staff that worked only at night-time; this was facilitated by the flexible shifts worked by the person in charge. Administration support was provided one day a week. Though very recently appointed to this post, the person in charge was satisfied that these governance arrangements were sufficient for her to exercise her role and responsibilities.

The improved staffing levels put in place in 2017 had been maintained and work had been completed on the staff rota to improve the consistency of staffing. There was a requirement for relief staff but these were a core group of staff who primarily worked only in this centre and only when required, for example to facilitate staff

training or the additional weekend staff hours. Based on the inspectors observations and feedback from staff staffing levels were sufficient to meet residents needs including specific requirements such as one-to-one support. Staff told the inspector that the improved staffing numbers had improved life for everyone, residents and staff and made the centre a much better place to work. The positive impact of these staffing levels was noted in resident' opportunities to access the community, the quality of their meals, the general pace of the centre and in the time that staff could give to residents.

However, the inspector did note that residents had complained about inadequate staffing levels at times in the day service (which is also operated by the provider); this had impacted negatively on residents lives in the centre as they had disrupted access to their day service; residents were not happy about this. This required monitoring and active management by the provider so as to minimise the individual and collective impact on residents, for example any resultant impact on behaviours of concern. The provider review of May 2018 had also specified the requirement for an assessment of any risk associated with staff skill-mix in the centre; there was a nursing presence on site each day from 08:00 to 20:00 but not at night-time. The rationale for and absence of this risk assessment is discussed again in the next section of this report.

Staff were provided with the education and training they required to respond appropriately to residents' needs and requirements. The inspector reviewed staff training records and found that staff attendance at mandatory training was in order, for example fire safety, safeguarding, and responding to behaviour of concern or risk. A requirement for additional training for staff in responding to seizure activity, for example, administering oxygen and emergency medicine had been identified and facilitated.

Improvement was required in the management and oversight of complaints. Records seen such as the complaints log and residents meetings demonstrated that residents knew how to complain and did complain; staff supported residents to record and progress their complaints, for example the reduced access to the day service as discussed above or peer to peer issues as they arose. However, what was not consistently demonstrated was the escalation of complaints that staff could not resolve, their final resolution and complainant satisfaction, and the review of complaints to identify patterns and trends so as to address and pre-empt any emerging issues.

The provider had effective systems for self-identifying areas of service and care provision that required improvement. The inspector reviewed the report of the unannounced provider review undertaken in the centre in May 2018. The inspector found this review to be robust; it followed up the progress made in implementing the previous action plan; this was found to be satisfactory. The reviewer consulted with residents and staff; the reviewer escalated findings within the wider organisation, for example to the director of services and members of the multi-disciplinary team (MDT); this reflected appropriate delegation of responsibility and accountability to other stakeholders for the quality and safety of the service received by residents. There was evidence of action taken based on the findings of this

internal review but all matters (based on these HIQA (Health Information and Quality Authority) inspection findings) were not fully or adequately resolved, for example the arrangements for the evacuation of residents, the identification and management of risk and the timely analysis of incidents. These and the requirement for further action are discussed in the next section of this report

Regulation 14: Persons in charge

The person in charge worked full-time and had the qualifications, skills and experience necessary to manage the designated centre. The person in charge had sound knowledge of the general operation and administration of the designated centre and her regulatory role and responsibilities.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels and arrangements were appropriate to the assessed needs of the residents. Residents received continuity of care and supports from a regular team of staff including regular relief staff.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had completed mandatory training within the specified time-frames. Staff were also facilitated to complete additional training that supported them to respond to and meet resident's needs.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found improved governance arrangements. This meant that the centre was consistently governed and resourced so as to ensure the delivery of safe, quality supports and services to residents. The provider had systems of review and

while areas identified for improvement may not have been fully resolved, overall the provider utilized the findings of reviews to inform and improve the safety and quality of the service.

Judgment: Compliant

Regulation 32: Notification of periods when the person in charge is absent

The provider was aware of its requirement to and had notified HIQA of any change to the person in charge of the designated centre. The associated prescribed information such as evidence of suitable qualifications and experience had also been submitted.

Judgment: Compliant

Regulation 34: Complaints procedure

Improvement was required in the oversight of the management of complaints to ensure that complaints were effectively managed.

Judgment: Substantially compliant

Quality and safety

As a result of the enhanced governance arrangements and the responsive actions taken by the provider the safety and quality of the service provided to residents had improved. However, areas were identified on inspection where further action was required to manage risk and ensure the appropriateness and safety of the service and supports received by residents. These areas included the identification and management of risk, consistent review of incidents and accidents, fire evacuation procedures, specific areas of healthcare and follow-through on all actions that issued from multi-disciplinary team (MDT) reviews.

The inspector reviewed the minutes of residents meetings and found that residents were consulted with in relation to their routines and the general operation of their home. The meetings were regular; all residents participated and contributed, staff recorded resident input and escalated any concerns or worries expressed, for example through the complaints procedure. Residents were kept informed of issues such as management changes and proposed admissions.

Residents' personal goals and objectives were integrated into the weekly meeting with each resident deciding what they wished to do in the coming week. This information was then communicated to staff on a white board in the staff office; this ensured that what was agreed was followed through on. Each meeting started by following up on the minutes of the previous meeting.

Based on the sample of records seen residents had a current person centred plan that they and their family as appropriate had contributed to. Staff maintained progress notes on each agreed goal and objective. On the day of inspection there was no observed barrier to the achievement of these goals as residents attended their day service as scheduled and had planned evening activities; resident's spoke of their continued enjoyment of local social clubs and trips made in the company of staff. Staff confirmed that recreational and social engagement was facilitated and supported by staff and adequate staff and transport were available. Residents spoke of their continued contact with family and home, and how important this was to them but how sometimes they were a little sad initially when they returned to the centre.

Residents confirmed that they continued to participate in the advocacy forum and had enjoyed the recent advocacy conference; residents shared with pride the 2019 advocacy calendar.

The sense of community in the centre was reflected in the commemorative mass planned for deceased residents to be held in the centre; family were invited and were to attend.

Residents still presented with behaviours of concern and risk but the inspection findings indicated that the provider had arrangements in place to support residents and these arrangements reduced the frequency, intensity and impact on peers of these behaviours. Residents were seen to have access to support from psychology, psychiatry and behaviour support. There was evidence that residents were consulted with in relation to the supports that they needed. Staff were seen to liaise with the CNS (clinical nurse specialist) in behaviour support in relation to the review and update of behaviour support plans. Staff spoken with said that while responding to and managing behaviour was still an ongoing requirement in the centre, they had the resources required to provide one-to-one support, to prevent and respond quickly to triggers, and to implement with effect the behaviour management guidelines. This would concur with the overarching review of recorded incidents completed by the inspector; this review found an overall reduction in incidents and in their intensity and impact particularly on peers.

Overall the provider had arrangements that supported resident health and well-being but there was a requirement for improvement. Staff reported that residents continued to have access to timely medical review from the local General Practitioner (GP) practice. Given the high dependency needs of some residents the GP came to the centre as required and on a regular basis. There was no reported challenge to residents accessing other healthcare services that they required; all of this was evident from records seen. The inspector saw that staff monitored resident health and well-being, represented and advocated for residents as necessary, for

example at MDT meetings.

Staff had reverted to cooking residents meals in the centre; this improved flexibility, choice and quality of meals for the residents. Residents made their own weekly menus choices with staff and meals were freshly prepared each day. The meals and dining experience on the day of inspection were inviting and appetising. Dietary practice was informed by recommendations from the dietitian or speech and language therapy; residents were seen to have been supplied with adaptive equipment that supported their independence at meal times.

However, the inspector found concerning inconsistency in the management of seizure activity and a requirement for the timely review of the protocol for the administration of the prescribed rescue medicine. Staff had received appropriate training and did seek medical advice on each occasion. However, the protocol in place did not demonstrate that it was based on the resident's presenting clinical requirements and how to respond to these so as to promote and maximise resident safety and well-being. In practice the response was inconsistent and dependent on the clinical advice available and given to staff. This inconsistency did not provide assurance or evidence that competing risks had been considered and assessed. The evidence to support this finding was discussed in detail with the provider who was requested to address the matter based on the verbal feedback received from the inspector.

In general each resident and their plan of care and support were seen to be the subject of regular review by the MDT; improvement was noted in the follow-up of actions agreed at the previous MDT. However, the inspector did note deficits where actions agreed as necessary were not consistently reviewed and monitored; this did not provide assurance as to the effectiveness of aspects of the support plan. For example an action that issued in June 2018 in relation to seeking expert clinical advice on the seizure activity protocol discussed above was not, based on these inspection findings followed through on to completion. The inspector also noted that while an MDT in April 2018 discussed the large number of behaviour related incidents brought for review, MDT's convened in June and July did not review the actions that had issued in April or any further incidents that had occurred; this review did not occur until September 2018.

Some work had been completed on improving the identification and management of risk, however, the inspector found that this was not sufficient to ensure and assure the safety of residents. There were core risks that had not been assessed to evaluate the level of risk posed, the adequacy of existing controls or the requirement for additional controls. For example the risk assessment of the adequacy of staff skill-mix requested by the provider review of May 2018 was not evidenced. This assessment was required to establish if additional supports were required by care staff so that they could effectively perform the role of key-worker, particularly where resident needs were more complex. As mentioned above the approach to the management of medical emergencies was not informed by an assessment of risk. In addition there was a requirement for a full review of the risk register. The risk register had not been updated to reflect changes in the cohort of residents, for example the impact of admissions to the centre on individual and

collective risks such as the risk of increased negative peer to peer relationships.

There was evidence to support that the oversight of accident and incidents and the associated records was not sufficiently consistent in the context of the challenges in this service. For example the inspector noted repeat observations made by the MDT that records submitted for review did not contain the detail required to support a robust analysis of the incident.

The current evacuation procedures were not adequate to ensure the timely evacuation of all residents if this was necessary. The provider had completed the fire safety upgrading works committed to at the time of registration; remedial works had been completed on the emergency lighting system and the fire detection system. There was documentary evidence that these systems were appropriately inspected and tested. All staff had completed regular fire safety training and each resident had a personal emergency evacuation plan (PEEP). There was a centre specific evacuation plan based on the level of staff assistance required by each resident.

The centre was fitted with automatically released fire resistant door-sets to create compartments that should support a progressive horizontal evacuation procedure suited to residents' needs and dependencies. However, deficits have been identified in the door-sets and staff were completing simulated full evacuations out of the building; satisfactory evacuation times were not however achieved given the number and dependencies of the residents. The provider review of May 2018 had recommended that the required remedial works be prioritised.

Regulation 13: General welfare and development

Resource issues in the day service had impacted negatively on resident access to opportunities for occupation and engagement.

Judgment: Substantially compliant

Regulation 17: Premises

The inspector saw that the premises had undergone recent refurbishment and presented as well maintained. The refurbishment while taking due regard of safety requirements (there was evidence that materials used were fire- resistant) was very personalised to the residents living in the centre, their needs and individual interests.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents were provided with meals that were freshly prepared each day based on their preferences and choices. Nutritional practice was supported by advice and recommendations from the relevant healthcare professionals. Staff spoken with understood the importance of providing residents with a quality dining experience; residents were seen to enjoy their meals.

Judgment: Compliant

Regulation 26: Risk management procedures

Improvement was required in risk management procedures as risk assessments were not in place for dealing with all situations where resident safety may have been compromised.

The risk register required updating to ensure that it was an accurate reflection of the centre.

The oversight of accident and incidents and the associated records was not sufficiently consistent so as to provide assurance in the context of the challenges in this service.

A manual handling plan seen had not been reviewed post admission to the centre.

Based on records seen the floor based hoist was overdue a service.

Judgment: Not compliant

Regulation 28: Fire precautions

The current evacuation procedures were not adequate to ensure the timely evacuation of all residents if this was necessary. Deficits had been identified in fire-resistant door-sets and consequently staff were completing simulated full evacuations out of the building; satisfactory evacuation times were not however

achieved given the number and dependencies of the residents.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspector noted deficits where actions agreed as necessary to provide each resident with safe, quality support were not consistently reviewed and monitored; this did not provide assurance as to the effectiveness of aspects of the support plan.

Greater clarity was required in some healthcare related care plans to ensure that they gave clear and sufficient guidance to staff, particularly for times when staff did not have direct access to nursing staff for advice and guidance.

Judgment: Substantially compliant

Regulation 6: Health care

The inspector found concerning inconsistency in the management of seizure activity and a requirement for the timely review of the protocol for the administration of the prescribed rescue medicine.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The provider had arrangements in place to support residents to manage behaviours of concern or risk to themselves and others. These arrangements reduced the frequency, intensity and impact on peers of these behaviours.

Judgment: Compliant

Regulation 8: Protection

There were policies and supporting procedures for ensuring that residents were protected from all forms of abuse. Staff had completed safeguarding training. Residents were assisted and supported to develop the knowledge, understanding and skills needed for self-care and protection; this was discussed each week with residents. It was clear that residents did understand and did report any concerns that they had; staff escalated these concerns and residents had access to the designated safeguarding officer.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were consulted with and had meaningful input into the organisation of the centre and the services that they received, for example through the weekly meetings with staff, through the complaints process and the advocacy forum.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 32: Notification of periods when the person in charge is absent	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Liosmor OSV-0004745

Inspection ID: MON-0020884

Date of inspection: 09/10/2018

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 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: • Complaints procedure in place for the reporting, resolving and maintaining of records in relation to complaints. • Complaints procedure reviewed with all staff at staff meeting on the 17th October 2018	
Regulation 13: General welfare and development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development: • Staff in place to support Individual to attend Day Services (05/11/18) • Complaints from 2 other residents regarding attendance at day service due to staff shortages & training discussed with Area Manager 10/11/18. Recruitment drive for additional relief staff underway.	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures:	

• Skills Mix risk assessment completed and escalated to Head of Community Services 07/11/18. • Business case for change in skill mix completed and escalated to Head of Community Services 07/11/18. Same submitted to Director of Services and funders for approval. • Full review of Risk Register underway, same to be completed by 31/11/18 • Risk assessment on the supports required to provide the adequate skill and knowledge to Care staff to carry out their role as keyworker completed on the 17/10/18 • Risk assessment on fire and safety hazards including arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents in the centre to be complete by the 31/11/18

Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • L1 fire panel and emergency lighting in situ • Phase 2 will be rolled out in line with fire inspection reports subject to securing funding from our funders. This continues to be discussed as part of Service Arrangement.	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: • PCP and manual care plan being reviewed by the keyworker to be complete by the 31/12/18 • CMN1 and PIC to link with keyworkers individually to review MPMP and PCP every 3 months Commencing 1/12/18 to provide support to Keyworker and ensure that actions from MDTs and goals are actioned and reviewed. • All actions from MDTS to be discussed at staff meetings and assigned accordingly. • Healthcare plans for all residents being reviewed by staff nurse and CNM1 to ensure they provide clear and concise guidance to care staff. This will be complete by the 31/1/19.	
Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care: • Epilepsy management plan for resident with epilepsy reviewed which includes the administration of the prescribed rescue medication on the 16/10/18. Risk assessment complete on the management of epilepsy. • Healthcare plans currently being reviewed by CNM1 and staff nurse for all residents , to be complete by the 31/1/19	

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.	Substantially Compliant	Yellow	10/11/2019
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	31/01/2019
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	Not Compliant	Orange	31/01/2019

	the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.			
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	31/01/2019
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	Orange	31/01/2019
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Substantially Compliant	Yellow	30/04/2019
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,	Substantially Compliant	Yellow	17/10/2018

	outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.			
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Substantially Compliant	Yellow	31/01/2019
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	31/01/2019