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:	Clann Mór 2
Name of provider:	Clann Mór Residential and Respite Company Limited by Guarantee
Address of centre:	Meath
Type of inspection:	Announced
Date of inspection:	29 & 30 August 2018
Centre ID:	OSV-0004929
Fieldwork ID:	MON-0021932

About the designated centre

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

Clan Mor 2 comprises of three community houses located in large towns in Co. Meath. Two of the houses are terraced bungalows located within a short walk of each other and the other is a large detached bungalow located approximately 25 kilometres away. The three houses support nine male and female adults who in line with the Statement of Purpose for the centre are assessed as requiring low support. Some residents have health care needs and are supported by staff as required in meeting their needs. All staff are community support workers who have been provided with training in order to meet the needs of the residents. Community facilitators are also employed who have some delegated managerial responsibilities in the centre. All of the houses are closed during the day Monday to Friday while residents are in day services.Transport is provided in the centre. All of the houses are within walking distance to local towns.

The following information outlines some additional data on this centre.

Current registration end date:	10/01/2019
Number of residents on the date of inspection:	9

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
29 August 2018	09:15hrs to 18:30hrs	Anna Doyle	Lead
30 August 2018	08:00hrs to 15:30hrs	Anna Doyle	Lead

Views of people who use the service

The inspector met seven of the residents residing in the centre and talked to all of them about their views on the quality of services provided there. The residents had also completed questionnaires with the help of staff which provided further information on their views.

Overall the residents gave very positive feedback about living in the centre. They spoke about a number of meetings where they were able to raise concerns to senior managers. One resident gave an example to the inspector about how residents had informed management that they did not like the colour of the front door in their home and this had been repainted.

All residents spoke very positively about the staff in the centre and one resident described them as being like family. The inspector also viewed records where a resident had raised a concern in the centre and found that management had responded to this quickly and effectively and kept the resident informed throughout.

Residents also said that they felt safe in the centre. They gave examples of how they were supported to maintain family supports and links with the community.

All residents spoke about being involved in running their own home, for example preparing meals, grocery shopping and doing their own laundry with staff support where they required it.

One resident spoke about one aspect of the service that they would like to see changed in relation to staffing levels in the centre. The inspector found that the provider was already aware of this and was taking steps to address this.

Residents for the most part enjoyed sharing their home with each other and laughed about how sometimes arguments happened but were quickly resolved.

All residents attended a day service and were very happy with these. During the week in the evening times they talked about been involved in a variety of activities which included music lessons, bowling and community groups. At weekends residents told the inspector that they either visited family or spent time relaxing if they wished.

Capacity and capability

This inspection was in response to the provider submitting an application to the Health Information and Quality Authority (HIQA) to renew the registration of the centre and to follow up on the actions from the last inspection in December 2017 where significant improvements had been required in fire safety systems in the centre.

In response to some of the findings at that inspection, the provider had attended a meeting in HIQA to provide assurances around this centre and other centres under the provider.

Overall the inspector found that the provider had implemented some improvements to the ongoing monitoring of services since the last inspection and it was evident that resident's autonomy in the centre was promoted.

However, there were areas of service provision that were under resourced as highlighted by the provider in a business case to the Health Service Executive (HSE). The areas included management structures within the wider organisation and staffing levels. The inspector found that this was impacting on the provider's ability to effectively monitor the quality of care in the centre and to achieve planned service objectives due to the limited contingencies available to ensure effective oversight of the centre in the absence of a person in charge.

For example, since the last inspection the person in charge position had been vacant on two occasions. This had required either the director of services or the service manager (as was the case at this inspection) to be appointed as the person in charge to ensure effective oversight of the centre.

However, the service manager was also the person in charge for two other centres under this provider as well as being assigned other roles within the organisation. The inspector found that this was not providing effective oversight of the centre as evidenced by the findings of this inspection.

In addition, as mentioned the provider had also highlighted that there was insufficient staffing levels during the day in some areas of the centre in order to meet the changing needs of residents. For example, all of the three houses were closed during the day from 10.00hrs to 15.30 hours. This had an impact on residents' choices or needs not to attend day services as evidenced both in the unannounced quality and safety review for the centre and in one incident report reviewed by the inspector.

While the inspector found that the management team responded to this on a day by day basis by employing relief staff as and when required it was not providing consistency of care for residents.

The inspector acknowledges that some progress had been made at the time of the inspection in response to this business case as additional funding had been made available to the provider to address some of the deficits outlined in the business case. A new person in charge had also been appointed to this centre and the provider was recruiting a new team leader within the organisation which would

contribute to effective management structures going forward.

In addition, both the service manager and the director of service demonstrated a strong commitment to providing for a safe quality service for residents, despite resource issues in the centre.

Since the last inspection a number of audits had being conducted to review the quality and safety of care such as finances and medication practices. However, there were no records to demonstrate whether recommendations from these audits had been followed up on. Assurances had to be requested in respect of one audit finding which related to one resident's personal possessions at the inspection.

An annual review had also been completed along with a six monthly unannounced visit. Some of the actions from these were still in progress at the time of the inspection.

The service manager facilitated the inspection and all staff met were aware of the interim arrangements, as were residents. They reported to the director of services who in turn reported to the board of management.

Community facilitators were also employed who had some oversight over care practices in the centre. An out of hours on call service was also provided to staff to seek support if required.

Staff spoken to were knowledgeable around the needs of the residents in the centre and said they felt supported in their role. All staff had been provided with mandatory training and other training to meet the needs of the residents which included basic life support and the safe administration of medication. However, some relief staff had not completed training on the administration of one prescribed medicine for a resident.

Staff meetings were held in the centre; although these had not been very frequent in the last number of months. Staff also received supervision which was facilitated by the service manager. Of the sample of records viewed the inspector found that areas of improvement identified were not always followed up on. A new schedule had been devised by the service manager to ensure that meetings and supervision were held regularly in the centre going forward.

There were no staff vacancies in the centre and contingencies were in place to cover planned and unplanned leave as regular relief staff were employed.

There had been no new admissions to the centre since the last inspection. Contracts of care already identified at another inspection did not include the services to be provided and references to insurance premiums that residents needed to pay in the centre were incorrect in this contract. The admission policy which had recently been reviewed did not include one of the requirements of the regulations.

Residents were aware of how to make a complaint. The inspector reviewed one complaint made and found that appropriate and timely action had been taken in

response to this.

Some records pertaining to Schedule 4 of the regulations were not in stored in the centre as required.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted the required documents as part of their application to renew the registration of the centre.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge arrangements were not effective at the time of the inspection.

Judgment: Not compliant

Regulation 15: Staffing

There was inadequate staffing levels in the centre as highlighted by the provider in their business case.

Judgment: Not compliant

Regulation 16: Training and staff development

Some relief staff had not completed training on the administration of one prescribed medicine for a resident.

Judgment: Substantially compliant

Regulation 19: Directory of residents

A directory of residents was available and maintained in the centre.

Judgment: Compliant

Regulation 22: Insurance

The provider had submitted insurance details as part of their application to renew the registration of the centre.

Judgment: Compliant

Regulation 23: Governance and management

There were no records to demonstrate whether recommendations from audits completed in the centre had been followed up on. Assurances had to be requested in respect of one action relating to personal possessions at the inspection.

The centre was not adequately resourced to ensure the effective review and monitoring of the care and support being provided in the centre.

Areas of improvement identified during supervision were not always recorded as being followed up.

Staff meetings were not being held regularly in the centre.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The admissions policy had recently been reviewed by the provider, did not take account of the need to protect residents residing in the centre.

The contracts of care in place did not specify the supports to be provided to residents in the centre and information recorded about residents having to pay

insurance was incorrect.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose for the centre outlined the care and support being provided in the centre. Some minor adjustments required to this document were submitted post inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector was satisfied that all incidents occurring in the centre had been notified to HIQA as required by the regulations.

Judgment: Compliant

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

The provider was aware of their obligation to notify HIQA in this event.

Judgment: Compliant

Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent

The provider was aware of their obligation to notify HIQA in this event.

Judgment: Compliant

Regulation 34: Complaints procedure

Complaints were been dealt with in a timely manner and there were records to demonstrate that the outcome of the complaint had been followed up with the

complainant who was satisfied with the outcome.

Judgment: Compliant

Regulation 21: Records

Some records were not stored in the centre which included:

A copy of the actual staff roster worked in the centre

A record of all complaints made in the centre.

Judgment: Substantially compliant

Quality and safety

Overall the inspector found that while residents appeared well cared for in the centre and informed the inspector that they were happy living there the issues identified earlier in this report were impacting on the quality and safety of the services being provided.

Since the last inspection the provider had instigated some improvements in fire safety, risk management and safeguarding. However, improvements were still required in all of these areas along with other regulations inspected.

Personal plans which the provider had highlighted as part of their own audits required review. The inspector found that the assessment of need was not comprehensive, did not include the changing needs of residents and the review of personal plans while taking place did not assess the effectiveness of the care being provided.

Residents had goals in place that were meaningful to them some of which included increasing their independent living skills. Residents said that they were happy with the goals in place and spoke about their future goals.

Residents who required support around positive behaviours had a support plan in place to guide practice. The inspector found that staff were knowledgeable around these supports.

The provider had also employed a psychologist on a part time basis to assist staff and residents in this area where required.

Since the last inspection a review had also taken place on restrictive practices. From

this review these practices had stopped.

Improvements had been made in the provision of fire safety equipment since the last inspection as emergency lighting and fire doors were now installed in all of the homes.

All staff had completed fire safety training in the centre and personal emergency evacuation plans had been updated. There were also records available to demonstrate a safe evacuation of residents from the centre both at night and during the day.

However, the inspector was not assured from speaking to residents and the person in charge around the evacuation procedures in place to support two residents in the centre who remained unsupervised in the centre at times. This had been an action from the last inspection. This was discussed with the service manager and addressed by the provider on the second day of the inspection.

In addition, fire checks were not being completed in line with current standards.

Risk management processes had improved since the last inspection. For example a risk register was now being maintained in the centre. Some improvements were still required to ensure that it was reviewed and included all potential risks.

The risk management policy had recently been reviewed but did not include all of the requirements specified under the regulations. In addition, some individual risk assessments had not been completed in relation to fire safety as already discussed in this report.

The inspector found responsive action was taken when incidents occurred in the centre. All of which were reviewed and recommendations were made to mitigate risks where required. The provider also had a proactive approach to the identification of environmental risks in the centre as staff completed health and safety checklists regularly from which areas of concern were reported.

All staff had completed training in safeguarding vulnerable adults. Staff met were aware of the different types of abuse and the procedures to follow in the event of an allegation of abuse. Residents said they felt safe in the centre and would report concerns to staff. However, there were no intimate care plans in place for residents who required support in this area.

Residents had adequate storage to store their personal belongings in the centre and were supported to manage and launder their own clothes. Residents were supported by staff where required to manage their financial affairs. There were some systems in place to ensure transparent records were maintained in this area. For example, staff reconciled residents' monies on a daily basis.

However, improvements were required to ensure that resident's money management supports were outlined in their personal plans to ensure transparency and promote their own independence in this area. As discussed earlier in this report financial audits had commenced in the centre and improvements were required in

the follow up of issues identified.

Regulation 10: Communication

Improvements were required to ensure that one resident's communication support needs were outlined in their personal plan in order to guide staff practice.

Judgment: Substantially compliant

Regulation 12: Personal possessions

There were no money management plans in place to guide the support required by each resident.

Issues identified through a financial audit review had not been followed up.

Judgment: Not compliant

Regulation 17: Premises

The premises were well maintained, homely and met the requirements of the regulations as evidenced at previous inspections of this centre.

Judgment: Compliant

Regulation 26: Risk management procedures

The risk management policy did not include all of the requirements specified under the regulations.

Improvements were required to the risk register maintained in the centre.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The inspector was not assured from speaking to residents and the person in charge of the evacuation procedures in place to support two residents in the centre who remained unsupervised in the centre at weekends. This was addressed by the provider on the second day of the inspection.

Fire checks were not been completed in the centre in line with current standards.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The assessment of need in place for residents was not comprehensive and had not been updated to reflect the changing needs of residents.

There were no support plans in place to guide staff practice for some residents identified needs.

The review of personal plans did not effectively review the care and support needs for each resident.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Residents had positive behaviour support plans in place where required to guide practice. Some residents spoken to were aware of the strategies implemented to support them. The provider had recruited a psychologist on a part time basis to support both staff and residents in this area. Since the last inspection restrictions in place had been reviewed and had ceased as a result of this review.

Judgment: Compliant

Regulation 8: Protection

There were no intimate care plans in place for residents who required support in this

area.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents were supported to exercise their rights. They were consulted on changes in the centre and were able to raise concerns through a number of forums. Residents had also been supported with some education around their legal rights. For example; how to make a will.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 32: Notification of periods when the person in charge is absent	Compliant
Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 21: Records	Substantially compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Clann Mór 2 OSV-0004929

Inspection ID: MON-0021932

Date of inspection: 29 & 30/08/2018

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: Team Leader was appointed and is PIC for Clann Mór 2. Interviews for an additional Team Leader are taking place in mid-October.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Funding has been enhanced to facilitate staffing which will support residents with changing needs.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff, including relief staff take part in mandatory training as required, this includes SAMS and SAMS refresher. Going forward medication administration review will be part of all Staff quarterly training. Oxygen training in one of the houses will be organized.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Going forward as part of the auditing process, personal possessions will be reviewed to include the use of gift vouchers.	

Community facilitators and Team Leader will audit houses on a three weekly basis. All actions identified in these audits will have a follow up audit action report to include name of person to complete action and date completed.

The Team Leader has taken responsibility for the effective review and monitoring of the care and support being provided in the centre. Additional staff have been resourced to support the changing needs of residents.

Going forward, any actions identified in staff supervision will be brought to management meetings for review and follow up.

Staff meeting schedule will be enhanced going forward.

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:

The admissions policy will be reviewed to include all requirements of Regulation 24, including the need to protect residents from peer abuse.

The contract of care will be reviewed to take into account the supports provided to residents and outline insurance cover.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:

Staff rosters are printed out and circulated to each house. Rosters for the following week are sent to houses every Friday. There is a copy of the roster in all houses at all times.

A copy of the complaints register will be placed in each house and updated every three months.

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:

If a resident requires support with communication, this will be recorded in their PCP. A communication folder will also be available for residents who have difficulty with communication.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:

The assessment of need is will be reviewed to include money management plans which will outline supports required for each resident.

All actions identified in Clann Mór audits will have a follow up audit action report to include name of person who completed action and date completed.

Regulation 26: Risk management procedures	Substantially Compliant

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

Risk management policy will be approved by Clann Mór board and will include the following specified risks: accidental injury to residents, visitors or staff, aggression and violence, arrangements for the identification, recording and investigation of, learning from, serious incidents or adverse events involving residents.

All existing risks in the centre have been reviewed and risk rated. Team Leader will audit all houses in the centre to identify any new risks and theses will be recorded in the risk register.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

A new fire alarm phone activation system has been installed in a house where three residents reside. When the fire alarm goes off, the system will activate a sequential call to the neighboring Clann Mór house, the on-call support, a member of the management team and the fire brigade.

Fire checks will be reviewed weekly in line with current standards for community dwellings.

Regulation 5: Individual assessment and personal plan	Not Compliant

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

A revised assessment of need is being compiled for each resident to reflect their changing needs. These assessments will then be reviewed twice a year or sooner if required. This revised assessment of need will guide the development of risk assessments, healthcare plans and positive behavior support plans. This document will guide staff practice.

Each house is audited every three weeks. These audits will ensure that support plans will be in place.

The PCP for residents is also under review and the updated PCP will inform the care and support needs of each resident.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

As part of the new assessment of need document, intimate care will be explored for each resident. If intimate care is required, a health care plan will be developed to guide staff and support the protection residents.

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 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Substantially Compliant	Yellow	19.10.2018
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	31.10.18
Regulation 14(4)	A person may be appointed as person in charge of more than one	Not Compliant	Orange	03.09.18

	designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.			
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	05.10.18
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	31.10.18
Regulation 21(4)	Records kept in accordance with this section and set out in paragraphs (6), (11), (12), (13), and (14) of Schedule 4, shall be retained for a period of not less than 4 years from	Substantially Compliant	Yellow	31.10.18

	the date of their making.			
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.	Not Compliant	Orange	03.09.18
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31.10.18
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	30.11.18
Regulation 23(3)(b)	The registered provider shall	Substantially Compliant	Yellow	05.10.18

	ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.			
Regulation 24(1)(b)	The registered provider shall ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.	Substantially Compliant	Yellow	17.10.18
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.	Not Compliant	Orange	26.10.18
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified	Substantially Compliant	Yellow	31.10.18

	risks: accidental injury to residents, visitors or staff.			
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: aggression and violence.	Substantially Compliant	Yellow	31.10.18
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.	Substantially Compliant	Yellow	31.10.18
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	31.10.18

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	30.08.18
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	31.10.18
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	30.11.18
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a	Substantially Compliant	Yellow	30.11.18

	review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.			
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	30.11.18
Regulation 08(6)	The person in charge shall have safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.	Substantially Compliant	Yellow	31.10.18