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

Name of designated centre:	Dunfirth Farm
Name of provider:	Health Service Executive
Address of centre:	Meath
Type of inspection:	Unannounced
Date of inspection:	13 March 2018
Centre ID:	OSV-0005451
Fieldwork ID:	MON-0021067

About the designated centre

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

At the time of inspection, the centre provided residential care and support for 32 adults on the autistic spectrum. The centre comprised of eight individual houses and six single unit apartments supporting both male and female adult residents. The majority of the residents had been living in the centre for more than 20 years. The centre was located in a rural setting on a large campus. The centre had a number of vehicles in place to transport residents to social and recreational activities in the community. The campus included a stand alone building, named the training unit, where a number of residents engaged in a activities such as art and cooking classes. There was also a smaller building, where pottery classes were undertaken. The campus had a large garden and a poly tunnel where some residents engaged in horticultural activities.

The centre was previously operated by the Irish Society for Autism (ISA). However, due to high levels of non compliance and risk to residents, HIQA issued a notice of decision to cancel and refuse the registration of the centre in May 2016. In accordance with Section 64 of the Health Act 2007, the chief inspector made alternative arrangements with the Health Service Executive (HSE) to take over the running of the centre. The HSE put a memorandum of understanding in place with an external company to support the day-to-day operations of the centre. The ISA were also included in the memorandum of understanding as they owned the property, land and a number of vehicles and employed the staff team. The HSE, in conjunction with the external company, were required to submit monthly risk reports to HIQA to outline the progress being made in supporting the centre to achieve compliance with the regulations. The HSE made a commitment to put in place a suitable provider who would make an application to be the registered provider for this centre. A tendering process for same was commenced in 2017 and a new provider had been identified at the time of inspection. However, the new provider had not taken over the running of the centre or submitted to HIQA an application to be the registered provider.

This was the third unannounced inspection in the centre. The last inspection was on 28 June 2017. The purpose of this inspection was to provide assurances to HIQA that the monthly risk reports being submitted were being implemented and to assess the overall quality and safety of service being delivered for residents during the period of transition whilst the new provider was being appointed and taking up their position.

The following information outlines some additional data on this centre.

Current registration end date:	31/10/2018
Number of residents on the date of inspection:	32

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
13 March 2018	10:00hrs to 18:00hrs	Maureen Burns Rees	Lead

Views of people who use the service

The inspector had the opportunity to meet with 10 of the 32 residents who lived in houses or apartments across the centre and observed elements of their daily lives at different times over the course of the inspection. Residents appeared to be relaxed, content and well cared for. There was a warm homely atmosphere observed in the centre.

The inspector found that residents were enabled and assisted to communicate their needs, wishes and choices which supported and promoted residents to make decisions about their care. Residents were actively supported and encouraged to maintain connections with their families through a variety of communication resources and facilitation of visits.

Residents spoken with told the inspector that they were happy and felt safe living in the centre, and that they enjoyed engaging in a number of activities both within the campus and outside within the community. Although, a number of residents were unable to tell the inspector about their views of the service, the inspector observed warm interactions between the residents and staff caring for them and that the residents were in good spirits. Staff spoken with outlined how they advocated on behalf of the residents and how they felt that each of the residents enjoyed living in the centre. A number of staff had been working in the centre for an extended period and it was evident had close relationships and understanding of the individual residents needs and support requirements. Staff were observed to support and interact with residents in a warm, caring and dignified manner.

Although the inspector did not have an opportunity to meet with the relatives of any of the residents, there was evidence that the current provider had engaged with residents and their family in 2017 regarding the changes to the governance arrangements which had occurred and were planned. However, there had been limited communication with residents, family or staff regarding the recent completed tendering process for a new provider.

Capacity and capability

This inspector found that while some improvements had been made with regard to the quality and safety of care, there remained significant improvements to be made in relation to the current governance and management arrangements, contracts of care and the statement of purpose.

The centre was managed by a suitably qualified, skilled and experienced person. He was supported by two team leaders. The person in charge had more than 20 years senior management experience and held a degree in psychology and a certificate in

management. He was found to have a good knowledge of the care and support requirements for residents living in the centre. He was in a full time post and was not responsible for any other centre. Staff members spoken with told the inspector that the person in charge and the two appointed team leaders supported them in their role. However, given the geographical size of the campus, the number of residents and the number of staff, it was not possible for the person in charge to be effectively engaged in the governance, operational management and administration of the centre, in its current make up, on a consistent basis.

There was a management structure in place that identified lines of accountability and responsibility. However, the governance arrangements in place were not robust and meant that the lines of accountability and responsibility were not clear. The person in charge reported to the general manager for disability services, HSE community health organisation 7(CHO7), who in turn reported to the chief officer (CHO7). However, the person in charge was employed by the previous provider. Some members of the staff team were employed by the HSE but others were employed by the previous provider. There was a limited human resources structure in place for the person in charge. The residents finances and some other finances for the operational running of the centre was controlled by the previous provider and the person in charge and current provider had no oversight of these arrangements. The HSE was responsible for the social fund and petty cash arrangements. The person in charge did not have control of a defined budget for the centre.

The provider had completed an annual review of the quality and safety of care in the centre and six monthly unannounced visits to assess the quality and safety of the service as required by the regulations. There was evidence that some actions had been taken to address issues identified.

A number of staff across the centre had been working with the residents over an extended period so provided consistency of care for the residents. The full complement of staff were not in place, which necessitated the use of agency staff. However, it was found that a regular panel of agency staff were being used and were rostered on shift with regular staff members. This ensured some consistency of care for the residents. On-call arrangements were in place for staff.

There were staff supervision arrangements in place. However, supervision for staff was not being undertaken in line with the frequency proposed in the providers policy. The person in charge and the team leaders provided supervision to the staff team.

A draft statement of purpose, dated November 2017 was in place but had not been approved by management or circulated to individual houses. It set out the aims, objectives and ethos of the designated centre. It also stated the facilities and services which were provided for residents.

Contracts of care were not available on some residents files reviewed, whilst in other files, contracts in place were not appropriate as they did not detail accurately the

service being provided or the fees payable.

Regulation 14: Persons in charge

The person in charge had appropriate qualifications and experience to manage a designated centre. However, he was unable to effectively engage in the governance and operational management of the centre to ensure it met its stated purpose, aims and objectives. This was directly related to the limited supports in place, and number of houses and size of the centre.

Judgment: Not compliant

Regulation 15: Staffing

The full complement of staff were not in place which necessitated the use of agency staff. It was noted that a regular panel of agency staff were used which provided some consistency.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff were not receiving supervision in line with the frequency proposed in the providers policy.

Judgment: Substantially compliant

Regulation 23: Governance and management

The governance and management systems in place did not promote the delivery of a high quality and safe service.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

Appropriate contracts outlining the services to be provided and fees to be paid were not in place.

Judgment: Not compliant

Regulation 3: Statement of purpose

A statement of purpose had been drafted but had not yet been approved by the provider or circulated to residents or their families.

Judgment: Not compliant

Regulation 31: Notification of incidents

A record of all incidents occurring in the centre were maintained and appeared where required, to be notified to the Chief Inspector and within the timelines required in the regulations.

Judgment: Compliant

Regulation 4: Written policies and procedures

A large number of policies had not been reviewed for an extended period and or did not contain appropriate information. For example referred to reporting arrangements associated with the previous provider.

Judgment: Not compliant

Quality and safety

The residents living in the centre appeared to receive person centred care and support which promoted their rights. However, improvements were required in relation to the personal support plans, behavioural support arrangements and the maintenance of the premises.

Overall, the inspector found that residents' well-being and welfare was maintained

by a good standard of care and support. However, the quality of the documentation of this care and support varied across the centre. A number of personal support plans reviewed reflected the assessed needs of the individual resident and outlined the support required to maximise their personal development in accordance with their individual health, personal and social needs and choices. However, this was not clearly recorded in other plans reviewed. A number of personal plans had not been formally reviewed at regular intervals with the involvement of the resident's multidisciplinary team, the resident and family representatives.

The inspector observed, and noted in speaking with staff, that residents were supported to engage in meaningful activities in the centre and within the community. However, in some cases this was not always recorded. The majority of the residents were engaged in programmes within the campus. Examples, included pottery, horticulture, art and cooking. Staff facilitated and supported the residents to to participate in activities that promoted community inclusion such as, cycling, swimming, the cinema, nature/ forest walks, social club, gym, bowling and going out to local restaurants and bars. Individual daily and weekly schedules were in place for some residents.

Overall, the units in the centre were found to be suitable to meet the resident's individual and collective needs in a homely way. Each of the residents had their own bedrooms which had been personalised to their tastes and choices. Some repainting and refurbishment work had been undertaken in individual houses. However, areas for improvement were identified in relation to the maintenance and repair of a large number of the houses and outside areas. Examples included, chipped and worn paint on wall and wood work, missing tiles and grouting in bathroom and toilet areas, and flooring and furniture in need of replacing.

Residents' communication needs were met in the sample of resident's files reviewed. Individual communication requirements were highlighted in residents' personal plans and reflected in practice. A number of the residents were non-verbal. There were communication tools, such as picture exchange and object of interest in place, to assist residents to choose food choices, activities, daily routines and journey destinations.

The residents were provided with a nutritious, appetizing and a varied diet. The timing of meals and snacks throughout the day were planned to fit around the needs of the resident. A weekly menu was agreed with residents.

Overall, the health and safety of residents, visitors and staff were promoted and protected. However, the risk management policy in place did not meet the regulatory requirements and included the escalated regulatory process for a previous provider. Some environmental risk assessments had been completed. However, individual risk assessments for residents had not been completed in some cases. This meant that some risks might not have been identified and as a result not have appropriate measures put in place to control and manage the risks. Health and safety audits were undertaken on a regular basis with actions taken were possible to address issues identified. There were arrangements in place for investigating and learning from incidents and adverse events involving residents.

This promoted opportunities for learning to improve services and prevent incidences.

Some residents were provided with appropriate emotional and behavioural support. Residents had access to a psychologist and a behavioural specialist. Behaviour support plans had been put in place for some residents and there was evidence that analysis had been undertaken of behaviours and possible triggers. However, suitable support plans were not in place for some residents who were identified to require same. This meant that the needs of these residents might not have been appropriately assessed and or met in a consistent manner by staff.

Regulation 10: Communication

The communication needs of residents had been appropriately assessed with appropriate supports put in place where required.

Judgment: Compliant

Regulation 17: Premises

Areas of the centre visited had a homely feel. However, a number of areas both inside and outside of individual houses required repainting and refurbishment.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents were provided with a nutritious, appetizing and varied diet.

Judgment: Compliant

Regulation 26: Risk management procedures

Robust risk management arrangements were not in place. For example, the risk management policy was not appropriate and individual risk assessments had not been undertaken for some residents.

Judgment: Not compliant

Regulation 28: Fire precautions

Suitable fire safety precautions were in place.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The quality of the documentation of the assessment and provision of care and support for residents varied across the centre. A number of personal plans had not been formally reviewed at regular intervals with the involvement of the resident's multidisciplinary team, the resident and family representatives.

Judgment: Not compliant

Regulation 6: Health care

Residents health care needs had been appropriately assessed and were being met by the care being provided in the centre.

Judgment: Compliant

Regulation 7: Positive behavioural support

Suitable behaviour support plans were not in place for some residents identified to require same.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially 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	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant

Compliance Plan for Dunfirth Farm OSV-0005451

Inspection ID: MON-0021067

Date of inspection: 13/03/2018

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: A new provider (Inspire Wellbeing) has been identified as part of a procurement process which took place in 2017. The HSE is currently working with the provider to agree and then action a transition plan. A full review has taken place as part of this transition / monitoring work. Oversight in the centre has commenced by the new provider. Further actions include a roster review, designations and skill mix of staff. Initial findings indicate need for an enhanced management team. HR ,risk management, quality and governance, training, corporate services, financial supports will be available through the new provider which will support the Person in Charge. Correspondence from the HSE to HIQA have provided timelines in relation to full handover of service, which will be completed by 30 June 2018. The current Person in Charge reports directly into the Assistant Director for the new provider	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Recruitment of suitably qualified staff will take place by Inspire Wellbeing as part of the overall handover of service provision. It is planned that this will include recruitment of the existing agency staff team which will ensure continuity of service. Recruitment of relief staff will be also carried out at this time. Current staff will also be subject to the TUPE process as part of the handover process. This will reduce the requirement for agency staff in the centre. A review of staff and skill-mix against the assessed needs of service users will take place and will be completed by 31 July 2018	
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 Inspire Wellbeing Staff Performance and Development Department will support the introduction of a structured framework to staff supervision, probation and performance monitoring in line with policies of Inspire Wellbeing.
The Staff Performance and Development Department will provide training to both supervisors and supervisees in supervision training by the 31 July 2018
There will be a full assessment of the staff training needs across the centre with the provision of both mandatory and assessed training needs will be completed by 31 July 2018
A line management structure will be put in place for all staff to ensure effective accountability and support systems for all staff. A full supervision schedule will be developed for all staff.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

A new provider (Inspire Wellbeing) has been identified as part of a procurement process which took place in 2017. The HSE is currently working with the provider on an agreed transition plan. A full review has taken place as part of this transition / monitoring work. Oversight in the centre has commenced by the new provider. Further actions include a roster review, designations and skill mix of staff. Initial findings indicate need for enhanced team leader support.

Full governance structure will be implemented as part of the new service provider. This will include clearly defined lines of authority and accountability across the centre, setting out roles and responsibilities for all areas of service provision. This will include HR ,risk management, quality and governance, training, corporate services, financial supports will be available through the new provider which will support the Person in Charge. The initial stages of assessment have commenced by the above named departments to complete baseline assessment and audits. Local risk register will be developed in addition to the corporate risk register. A process for internal audits will be put in place.
Monthly monitoring visits will also take place by the Assistant Director and a Service improvement Plan will be identified following each visit. This is in addition to the six monthly and annual reviews which will take place. A review of staff and skill-mix against the assessed needs of service users will take place and will be completed by 31 July 2018

Correspondence from the HSE to HIQA have provided timelines in relation to full handover of service, the handover will be completed before the 30 June 2018.
Recruitment of suitably qualified staff will take place by Inspire Wellbeing as part of the overall handover of service provision. It is planned that this will include recruitment of the existing agency staff team and relief panel will ensure continuity of service. This process will be guided by the requirements of the TUPE framework. This is currently being worked towards by all stakeholders.
The current Person in Charge reports into the Assistant Director for the new provider

Mechanisms will be put in place to monitor annual reviews and recommendations will be put in place.

A Communication Strategy will be shared with all stakeholders by the 30 May 2018 in regards to the New Service Provider systems and processes

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:

A new contract of care will be issued to all service users from Inspire Wellbeing by the 30 June. This will include services to be provided, care and welfare supports available and fees to be paid.

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

Draft Statement of Purpose has been issued to Inspire Wellbeing for their review and adaptation as required. This will then be submitted to the Authority by the 31 May 2018

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

Full suite of policies and procedures (inclusive of Schedule 5 policies) which will be accessible to all staff online, will be introduced by Inspire Wellbeing by the 30 June 2018. A schedule for review of each policy and procedure will also be put in place.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Costings and estimates for all works including paving, lighting, painting, replacement windows, fire panels, furnishings, kitchens and bathrooms have been provided to the HSE and are awaiting approval. The HSE are continuing negotiations for the formal handover of a lease arrangement for the property to allow the HSE to become the de-facto landlord. Once complete this will allow the HSE property Dept. to liaise with the new provider to provide for a full schedule of necessary and cosmetic works to bring the premises into compliance. A clear schedule of works will be developed and agreed by the HSE and Inspire Wellbeing, this will be developed by 30 June 2018. Ongoing maintenance and cosmetic works are taking place on a day to day basis as issues arise

Regulation 26: Risk management procedures	Not Compliant

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

The appointment of a new provider Inspire Wellbeing brings with it a Corporate services Dept including a Risk Management brief. A full survey of the centre will be undertaken by the Health and Safety team. A full risk review of all residents will identify gaps in the individual risk assessments and provide for a full individual risk assessment. A survey of the site and activities will allow for a full service specific risk framework.
The management of risk will be integrated into the new providers risk management framework with clear indications of responsibilities and timeframes.
A full Business Continuity Plan will be developed containing each identified risk to site within the departmental risk register and corporate risk register, this will be completed and cascaded to all staff by 31 July 2018, followed by monthly reviews there after.
Staff training will be provided as an ongoing developmental piece of work across the service.

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 new provider has commenced on site with a prioritization for a full assessment of need of each resident. The new provider will introduce a suite of new support planning, health and welfare documentation. A full schedule is to be implemented of health, support planning and multi-disciplinary reviews alongside provision of annual full review including all relevant stakeholders. The full assessment of need will be completed by 31 July 2018. A matrix of the service wide review processes will be implemented with a service wide perspective held with the PIC

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
A full assessment of need is to be completed on all service users and a schedule of prioritization for development of behavioural support plans.
A meeting of the multi-disciplinary team will identify the initial prioritisations. The first monthly MDT meeting will take place in June 2018, and monthly thereafter

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 14(4)	A person may be appointed as person in charge of more than one 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.	Not Compliant	Orange	30 June 2018
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.	Substantially Compliant	Yellow	31 July 2018
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31 July 2018
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30 June 2018
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	30 June 2018

Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	30 June 2018
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 July 2018
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Not Compliant	Orange	30 June 2018
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	30 June 2018
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	31 July 2018
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Orange	31 May 2018

Regulation 03(3)	The registered provider shall make a copy of the statement of purpose available to residents and their representatives.	Not Compliant	Orange	30 June 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.	Not Compliant	Orange	30 June 2018
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Not Compliant	Orange	31 July 2018
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Not Compliant	Orange	01 Sept 2018
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the	Not Compliant	Orange	01 Sept 2018

	effectiveness of the plan.			
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Not Compliant	Yellow	01 Sept 2018
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	01 Sept 2018