Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	Longlands
Name of provider:	St Michael's House
Address of centre:	Co. Dublin
Type of inspection:	Announced
Date of inspection:	30 January 2019
Centre ID:	OSV-0002391
Fieldwork ID:	MON-0022466

About the designated centre

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

The designated centre is based in a suburban area of North County Dublin and is comprised of one detached two storey building. On the ground floor of the centre there is an entrance hallway, two living rooms, a staff sleepover room and office space, three resident bedrooms, a large bathroom with wet room facilities, a utility room, and a large kitchen and dining space. The first floor of the building contains three resident bedrooms, a bathroom, a hot press, and an additional toilet. There is a driveway to the front of the building and a garden to the rear with an outdoor dining area. The centre provides a residential support service to six individuals and there is a person in charge employed in the centre with a team of social care workers.

The following information outlines some additional data on this centre.

Current registration end date:	13/07/2019
Number of residents on the date of inspection:	6

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as 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
30 January 2019	09:45hrs to 18:35hrs	Thomas Hogan	Lead

Views of people who use the service

The inspector met with five residents availing of the services of the centre throughout the period of the inspection. Family members of two residents were also met with by the inspector. In addition, six completed questionnaires were made available to the inspector which captured responses to a range of areas including satisfaction with the service, accommodation, food and mealtime experience, visitor arrangements, residents' rights, activities, care and support experience, staff, and complaints. Feedback received by the inspector from residents, family members and through a review of the completed questionnaires was very positive and communicated a high level of satisfaction with the services provided by the centre.

Capacity and capability

Overall, the inspector found that this was a good centre and residents were supported and cared for in an appropriate manner. There were; however, mixed findings across the regulations inspected against and a number of areas were identified which required improvement and development in order to ensure regulatory compliance. Some strong areas identified by the inspector included the person-centred culture which had been established and promoted in the centre. Residents were supported and cared for in a timely fashion and staff members were observed to be very knowledgeable of residents' individual needs. Areas of non-compliance identified by the inspector included: a deficit in the numbers of staff required to fully meet the needs of residents; a number of deficits were identified in mandatory staff training areas; and policies and procedures required by the regulations were not in place or had not been reviewed as required in some cases.

A review of the centre's written policies and procedures was completed by the inspector and it was found that one policy set out as being required was not in place and a number of policies had not been reviewed in the required time frames by the registered provider.

A review of staffing arrangements found that there was an appropriate skill mix amongst the staff team employed in the centre.The centre had begun to provide services during the day to one of its residents who required this. As a result additional resources were made available to meet this need. However, this had created increased demand on the rota with staff required during the day. While efforts were made to staff this arrangement within current resources there was a significant reliance upon agency and relief staff. The provider had requested funding in order to recruit additional staffing this was yet to be sanctioned.

The inspector reviewed staff duty rosters found that planned and actual rosters were maintained in the centre. The inspector found that the name of the centre was not listed on any of the roster documents and in some cases staff members' surnames were not recorded. There was a notable reliance on relief, agency and additional staff hours in the centre. This was found to impact on the ability to provide continuity of care and support to residents on occasions. The inspector reviewed a sample of three staff files and found that all documents required by Schedule 2 of the regulations were present and satisfactorily maintained.

A person in charge had recently been appointed to the centre by the registered provider. The inspector met with the person in charge at the time of the inspection and found they were knowledgeable of the relevant legislation, regulations and national policy. The person in charge demonstrated an in depth awareness of residents' needs and was very responsive to areas of non-compliance which were identified at the time of inspection.

The inspector reviewed staff training records available in the centre with the person in charge. Training records were only available for permanent staff members and as a result records were not available for relief or agency staff members who worked in the centre. A review of records for permanent staff members was completed by the inspector and it was found that a number of staff members had not completed training or refresher training in a number of mandatory areas as outlined by the centre's policies and procedures. The inspector found that a training plan had been devised by the person in charge to address the deficits in this area.

The inspector found that there were systems in place in the centre for both the formal and informal supervision of staff members, however, one-to-one supervision meetings were not held with staff members as frequently as required by organisational policy. In the case of two staff files reviewed, neither were found to have had one-to-one supervision meetings on six occasions in 12 months as required. The inspector noted that in the case of one of the two staff files reviewed, a staff member was recorded as having only one supervision meeting in 2018 and one in 2017. The content of supervision meetings was observed to be heavily focused on resident matters and was limited on areas such as staff development and improvement. For example, none of the supervision records reviewed had any details recorded of discussions being held regarding matters such as safeguarding and protection or fire safety.

A review of governance and management arrangements in the centre found that improvements were required in the oversight of care and support being delivered to ensure that a high standard was achieved and maintained. While there were a suite of audits and reviews being completed, these had failed to self-identify areas which required development and improvements or which were in non-compliance with the regulations. For example, in an annual review for 2017, the author stated that all required policies as procedures were present in the designated centre, however, at the time of inspection the person in charge confirmed that one policy relating to staff recruitment, selection and vetting was not present. Similarly, in a report of a six monthly unannounced visit to the centre by a person on behalf of the registered provider in July 2018, the author stated that there were no concerns with risk

assessments completed and that they were "adequate, proportionate and in date" despite findings of the contrary being identified by the inspector at the time of inspection. In addition, the author failed to identify concerns relating to fire safety and staff supervision through the completion of this assessment. The person in charge confirmed to the inspector that arrangements were not in place for the performance management of staff members as required by the Regulations.

Regulation 14: Persons in charge

The person in charge demonstrated appropriate knowledge of their legislative and regulatory responsibilities.

Judgment: Compliant

Regulation 15: Staffing

There was a shortcoming observed in the numbers of staff members employed which arose as a result of additional supports being put in place to support residents availing of an integrated day service. The name of the centre was not listed on any of the roster documents and in some cases staff member surnames were not recorded. There was a notable reliance on relief, agency and additional staff hours in the centre. This was found to impact on the ability to provide continuity of care and support to residents on occasions.

Judgment: Not compliant

Regulation 16: Training and staff development

Training records were only available for permanent staff members and as a result records relating to training were not available for relief or agency staff members who worked in the centre. A review of records for permanent staff members was completed by the inspector and it was found that a number of staff members had not completed training or refresher training in a number of mandatory areas as outlined by the centre's policies and procedures. The deficits in training were as follows:

- three staff members had not completed training or refresher training in first aid
- one staff member had not completed training or refresher training in the safe administration of medication

- two staff members had not completed training or refresher training in safeguarding vulnerable persons
- two staff members had not completed training or refresher training in clamping procedures
- one staff member had not completed training or refresher training in risk assessments
- one staff member had not completed training or refresher training in positive behaviour supports and
- one staff members had not completed training or refresher training in behaviours which challenge.

One-to-one supervision meetings were not held with staff members as frequently as required by organisational policy. The content of supervision meetings was observed to be heavily focused on resident matters and was limited on areas such as staff development and improvement.

Judgment: Not compliant

Regulation 22: Insurance

The centre was found to have been insured against accidents and injury to residents.

Judgment: Compliant

Regulation 23: Governance and management

Internal auditing and review mechanisms failed to self-identify areas which required development and improvements or which were in non-compliance with the Regulations. The person in charge confirmed to the inspector that arrangements were not in place for the performance management of staff members as required by the Regulations.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

A revised statement of purpose (dated 01 February 2019) was provided to the inspector following the inspection. This revised and updated document was found to

contain all required information as set out in the Regulations.

Judgment: Compliant

Regulation 4: Written policies and procedures

A policy on the recruitment, selection and vetting of staff was found not to be in place in the centre. In addition, a number of policies were found not to have been reviewed in the required time frames. They were the policies on:

- provision of behavioural support
- use of restrictive procedures and physical, chemical and environmental restraint
- residents' personal property, personal finances and possessions and
- the creation of, access to, retention of, maintenance of and destruction of records.

Judgment: Not compliant

Quality and safety

The inspector found that overall, there was clear evidence that care and support being provided to residents was person-centred and of a reasonably good standard. Families and staff members spoken with by the inspector felt that residents were safe while availing of the services of the centre. There were some areas of non-compliance identified by the inspector and these related mainly to the area of fire safety, risk management and medication management. The inspector found that improvements were required in these areas to ensure compliance with the regulations going forward.

The inspector completed a full walk through of centre in the company of the person in charge. The centre was observed to be clean throughout and appeared to be of sound construction. All residents were found to have their own individual bedrooms and these were decorated in line with residents' personal tastes and preferences. There were adequate private and communal spaces provided in the centre and sufficient numbers of bathrooms, showers and toilets. There centre was appropriately equipped with aids to support and promote the full capabilities of residents and was accessible for both fully mobile and wheelchair users. Some damage was noticed to beading which was in place along skirting boards in the hallway area of the ground floor which required replacement.

The inspector found that a risk management policy (dated April 2016) in place in the centre did not contain all required information as set out in the Regulations. A risk

register maintained in the centre was reviewed by the inspector. It was found that not all risks had been identified and assessed. For example, the risk of residents experiencing abuse had not been considered or assessed. Where risks had been identified, they were all risk rated as 'low', with the exception of one risk. The inspector found that in some cases that risks were not appropriately risk rated. The inspector completed a review of incident, accident and near miss records for the period of 2018 and 2019. Appropriate follow up actions were found to have taken place in the cases of all records reviewed.

The inspector reviewed fire safety measures in place in the centre and found that appropriate fire containment measures were not in place. Two fire doors were observed to have been wedged open and another fire door was blocked from closing due to the presence of furniture.

A review of fire drill records found that seven drills were completed in the centre in a two year period. In the case of two fire drills reviewed by the inspector, listed follow up actions were found not to have taken place. For example, in one case it was recorded that the fire drill was to be discussed at an upcoming team meeting, however, minutes from the team meeting did not reflect that this matter was discussed.

A number of personal emergency evacuation plans (PEEPs) were reviewed by the inspector. While in general these documents clearly communicated the supports required by residents in the event of a fire or emergency, in one case the inspector found that the plan was not reflective of the resident's needs. Findings from a fire drill were not included in the PEEP guidance and as a result did not inform the reader of how to appropriately support the resident in the event of an evacuation.

A review of medication storage arrangements found that medication cabinet keys were not stored in a secure manner when not in use by staff members. The inspector observed that the keys to the medication cabinet were stored in an unlocked key box attached to the wall of the staff sleepover room which also acted as the staff office. Blister packed medications contained within the medication cabinet were found not to have expiry dates available. All non-blister packed medication had expiry dates listed and the inspector found that these medications were within their stated expiry dates. The inspector reviewed prescriptions and medication administration records for two residents. In both cases the inspector found that staff members had recorded administering incorrect medications to the residents on a total of four occasions. This had not been previously identified by the staff team. The inspector found that PRN medications (medications administered as the need arises) were supported by PRN guidelines; however, these were not signed by a prescribing clinician and were not clear as to the criteria for administering the medication. While there were assessments completed regarding the self-administration of medication by residents, the inspector found that not all assessments had a stated outcome and as a result it remained unclear if the residents concerned had the capacity to self-administer their medications.

As previously mentioned in this report, the inspector reviewed all incident and accident recorded as having occurred in the centre for 2018 and 2019. No incidents

or accidents recorded involved residents experiencing abuse. An internal concern raised by a staff member was reviewed in detail by the inspector and it was found that it had been managed appropriately and in line with national policy. Family members and staff members spoken with all stated that they felt residents were safe while availing of the services of the centre. Staff members demonstrated appropriate knowledge of the types of abuse and the actions to take if abuse was witnessed or suspected.

Regulation 17: Premises

Some damage was noticed to beading which was in place along skirting boards in the hallway area of the ground floor which required replacement.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

A risk management policy (dated April 2016) in place in the centre did not contain all required information as set out in the Regulations. The policy did not outline:

- the arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents or
- the arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measured might have on the residents' quality of life have been considered.

All risks present in the centre had not been identified and assessed. The inspector found that in some cases that risks were not appropriately rated.

Judgment: Not compliant

Regulation 28: Fire precautions

Appropriate fire containment measures were not in place in the centre. The inspector observed two fire doors wedged open and another fire door was blocked from closing due to the presence of furniture. Some follow up actions listed on fire drill records were found not to have been completed. The inspector found that in the case of one resident a PEEP was not reflective of their needs.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Medication cabinet keys were found not to be stored in a secure manner when not in use. Blister packed medications contained within the medication cabinet were found not to have expiry dates available. Staff members had recorded administering incorrect medications on four occasions to two residents. This had not been previously identified by the staff team. PRN medication guidelines were not signed by a prescribing clinician and were not clear as to the criteria for administering the medication. While there were assessments completed regarding the self-administration of medication by residents, the inspector found that not all assessments had a stated outcome and as a result it remained unclear if the residents concerned had the capacity to self-administer their medications.

Judgment: Not compliant

Regulation 8: Protection

Staff members spoken with by the inspector demonstrated appropriate knowledge of the types of abuse and the actions to take if abuse was witnessed or suspected.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Longlands OSV-0002391

Inspection ID: MON-0022466

Date of inspection: 30/01/2019

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: In response to the area of non-compliance found under Regulation 15 (1) • A roster review will be completed for the centre and the Registered Provider will ensure the provision of consistent staffing with suitably qualified staff for the centre will be in place in meeting the needs of the residents. • A DSAMT for additional funding for an Individualised Day Service for one resident will be reviewed and submitted to the HSE. In response to the area of non-compliance found under Regulation 15 (3) • The PIC, Service Manager and the Administrator will complete a roster review for the centre to ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis. In response to the area of non-compliance found under Regulation 15 (4) • Going forward the PIC will ensure that the centre's name is on all planned and actual rosters. • The PIC will also ensure full names and grades of all staff will be on each roster.	
Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development: In response to the area of non-compliance found under Regulation 16 (1) (a) • The Registered Provider will co-ordinate with St Michaels House training department to review the relief staff that work in the centre's training records to ensure they are up to date with the required mandatory training and all outstanding training will be scheduled. • The Person in charge will liaise with the organisations training department and will review and update all required mandatory training for the centre and schedule the mandatory training as required. In response to the area of non-compliance found under Regulation 16(1)(b) • The Person in Charge will complete a schedule of supervision meetings with the staff team in the centre in line with the revised and updated organisations Staff Supervision and Support Policy.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The compliance plan response from the registered provider did not adequately assure the Office of the Chief Inspector that the actions will result in compliance with the regulations. In response to the area of non-compliance found under Regulation 23(1)(c) • The Registered Provider will ensure that all future audits, unannounced visits, and Annual Reviews will identify any key risks and areas of non-compliance within the centre, and will outline a plan of action to address any such deficits. In response to the area of non-compliance found under Regulation 23 (3)(a) • The Registered Provider will ensure that Supervision and Support meetings will take place 4 time per year for each staff member in the centre. The structures in place within this policy allow for all PICs to provide support and to identify development opportunities for all of their team specifically in relation to their roles and the services they provide. The policy also is designed to identify performance related concerns that will be addressed. • Pending the agreement and implementation of a national Performance Achievement	

Scheme, the St. Michael's House Supervision and Support policy provides a robust framework to ensure the organisation is compliant in this regard.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
In response to the area of non-compliance found under Regulation 4 (1)

• The Registered Provider is currently revising and updating the policy relating to the provision of positive behavioural support.

• The Registered Provider is currently revising and updating the policy relating to the use of restrictive procedures and, and physical, chemical and environmental restraint.

• The Registered Provider will update the policy relating to the creation of, access to, retention of, and the maintenance and destruction of records, to reflect the new GDPR legislation.

• The Registered Provider will update the policy relating to the recruitment, selection and vetting of staff. The Provider currently utilises the HSE Garda vetting policy, which applies to all section 38 agencies.

In response to the area of non-compliance found under Regulation 04 (3)

• The Registered Provider will review and update all schedule 5 policies in line with Regulation 04(1) and 04(3)

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
In response to the area of non-compliance found under Regulation 17(1)(b)

• The Person in Charge will submit a maintenance request to the Technical Services Dept to replace the beading along the skirting boards in the hallway area of the ground floor.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
In response to the area of non-compliance found under Regulation 26(1)(d)

• The Registered Provider will update the Risk Management policy to address the arrangements for the identification, recording, investigation of and learning from serious incidents or adverse events involving residents.

In response to the area of non-compliance found under Regulation 26(1)(e)

• The Registered Provider will update the Risk Management policy to address the arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the residents quality of life have been considered.

In response to the area of non-compliance found under Regulation 26(2)

• A Risk Assessment in relation to Safeguarding has been added to the centres Risk Register.

• A full review of all designated centre risks and proportionate risk allocation will be completed with the PIC, Service Manager and the Health and Safety officer.

• The PIC is now trained in the management of risk and in consultation with the service manager and the health and safety office they will develop systems in the centre for the assessment, managements and ongoing review of risk, which include a system for responding to emergencies

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
In response to the area of non-compliance found under Regulation 28(2)(b) (ii)

• The Person in Charge will follow up with the organisations Fire safety officer to ensure that the self-closing mechanisms identified during the inspection are addressed

• In line with the Regulation all Personal Emergency Evacuation Plans (PEEPs) will be reviewed at least annually or sooner in the event of changing needs.

In response to the area of non-compliance found under Regulation 28(2)(c)

• One PEEP identified in the Report that was not reflective of the Residents needs will be reviewed by the PIC and the Organisation Fire Officer.

• The fire doors found by the Inspector to be wedged open are now closed.

• The furniture blocking the means of escape has now been removed allowing for the safe egress of Residents in the event of fire evacuation.

In response to the area of non-compliance found under Regulation 28(3)(a)

• The Registered Provider will review and ensure that there are comprehensive arrangements are in place for the detection, containment and extinguishing of fire

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
In response to the area of non-compliance found under Regulation 29 (4) (a)

• A new medication cabinet key box has been purchased for the centre and the Person in Charge will ensure all medication is stored securely.

In response to the area of non-compliance found under Regulation 29 (4) (b)

• The PIC has obtained a letter from the medication supplier which states that the blister packs supplied to the designated centre weekly has a minimum expiry date of 3 months from the date the centre receives them.

• The PIC will contact the prescribing Doctor to review PRN guidelines and sign off on them.

• The PIC will request the organisation Health and Medical Trainer to meet the staff team in order to review the process of medication administration.

In response to the area of non-compliance found under Regulation 29(5)

• The PIC will complete assessments for the self-administration of medications with all residents in the centre to determine their capacity to self-administer their medication.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	01/01/2019
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	01/01/2019
Regulation 15(4)	The person in charge shall ensure that there is a planned and	Not Compliant	Orange	01/01/2019

	actual staff rota, showing staff on duty during the day and night and that it is properly maintained.			
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.	Not Compliant	Orange	30/06/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/06/2019
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	31/08/2019
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.	Substantially Compliant	Yellow	30/06/2019
Regulation	The registered	Substantially	Yellow	31/12/2019

23(3)(a)	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.	Compliant		
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Not Compliant	Orange	31/05/2019
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified,	Not Compliant	Orange	31/05/2019

	and that any adverse impact such measures might have on the resident's quality of life have been considered.			
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	30/06/2019
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/06/2019
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/04/2019
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/06/2019
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering,	Not Compliant	Orange	30/04/2019

	receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.			
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	30/05/2019
Regulation 29(5)	The person in charge shall ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the	Substantially Compliant	Yellow	30/05/2019

	nature of his or her disability.			
Regulation 04(1)	The registered provider shall prepare in writing and adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	30/12/2019
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	30/12/2019