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:	Navan Adult Residential Service
Name of provider:	RehabCare
Address of centre:	Meath
Type of inspection:	Announced
Date of inspection:	16 January 2019
Centre ID:	OSV-0002674
Fieldwork ID:	MON-0022489

About the designated centre

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

The designated centre is located on the outskirts of a town in Co.Meath and is operated by RehabCare. It provides community residential services for a maximum of five adults with a diagnosis of autism spectrum disorder, male or female, over the age of 18. The designated centre is a two storey house which consists of two living rooms, kitchen/dining area, conservatory, a staff sleep over room, two bathrooms and five individual bedrooms (two of which were en-suite). There was a garden to the rear of the centre which contained an ancillary building which consisted of an office, utility room and snoozelene room. The centre is located close to amenities such as shops, cafes and banks. The centre is staffed by a person in charge and social care workers.

The following information outlines some additional data on this centre.

Current registration end date:	22/06/2019
Number of residents on the date of inspection:	4

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
16 January 2019	09:45hrs to 19:00hrs	Conan O'Hara	Lead
16 January 2019	09:45hrs to 19:00hrs	Thomas Hogan	Support

Views of people who use the service

The inspectors had the opportunity to meet and spend time with the four residents during the inspection. A number of residents who spoke with the inspectors stated that they feel safe in the centre. In addition, feedback on the quality and safety of the service were taken from a review of questionnaires completed by the residents.

Overall, the residents view of the service and support they received was positive. Throughout the inspection, inspectors observed that residents appeared relaxed and comfortable in their home. In addition, positive interactions were observed between residents and staff.

Capacity and capability

Overall, there was governance and management systems in place to oversee the centre. However, improvements were required in the effective oversight of the centre, staffing, training and policies.

There was a clearly defined management structure which provided oversight of the service. The centre was managed by a suitably qualified and experienced person in charge who demonstrated good knowledge of the residents. The provider undertook quality assurance audits including the six monthly unannounced provider visits and annual reviews. However, improvements were required to ensure the centre is effectively monitored and appropriate to residents' needs. For example, the six monthly provider visits were not carried out within the six monthly time-frame and inspectors found that the annual review didn't identify key areas for improvement such as fire doors. In addition, considering the cumulative non compliances identified on inspection, inspectors were not assured that the governance and management arrangements in place ensured a safe and effective service.

The inspectors reviewed a sample of staff rotas and found that improvements were required to ensure that there was a planned and actual roster maintained which included full names of all staff working within the centre. The inspectors found that, on the day of inspection, there was an appropriate number and skill mix of staff to meet the assessed needs of the residents. The centre was currently operating with regular reliance on relief and agency staff in order to maintain the staffing levels. While the provider had made efforts to ensure these were familiar staff, the inspectors found that this did not ensure that residents received continuity of care and support at all times. For example, in October 2018, 31 shifts were covered by five agency or relief workers. In addition, the inspectors reviewed a sample of

staff files and found that not all of the information and documents as required by Schedule 2 of the regulations were in place.

There were systems in place for the training and development of staff. A sample of staff training records were reviewed and inspectors found that the majority of staff had up-to-date mandatory training. However, not all staff had completed training in fire safety, safeguarding de-escalation techniques. This meant that not all members of the staff team had the skills necessary to respond to the needs of the residents in a capable and safe way. The centre manager informed inspectors that this training had been scheduled.

A sample of incidents and accidents were reviewed and the inspectors found that all incidents were notified to the Office of the Chief Inspector as required by the Regulations.

The service being delivered to residents was observed to be in keeping with the centre's current statement of purpose dated January 2019. The statement of purpose contained all of the information as required by Schedule 1 of the regulations.

The previous inspection identified a number of polices required under Schedule 5 of the regulations which required review. The provider had addressed this and the policies were now in place and up-to-date. However, at the time of the inspection the policies on the Provision of Behavioural Support and Staff Training and Development required review as the review period had exceeded three years. This had been self identified by the provider.

Regulation 14: Persons in charge

The person in charge was employed on a full time basis and had the relevant qualifications, skills and experience to fulfill the role. The person in charge demonstrated good knowledge of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of staff. A sample of staff training records were reviewed and inspectors found that the majority of staff had up-to-date mandatory training. However, not all staff had completed training in fire safety and safeguarding de-escalation techniques.

Judgment: Substantially compliant

Regulation 22: Insurance

The provider had an insurance policy in place.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure which provided oversight of the service. However, improvements were required to ensure the centre was effectively monitored and appropriate to residents' needs. For example, the six monthly provider visits were not carried out within the six monthly time frame and inspectors found that the annual review didn't identify key areas for improvement such as the need for fire doors. In addition, considering the cumulative non compliances identified on inspection, inspectors were not assured that the governance and management arrangements in place ensured a safe and effective service.

Judgment: Not compliant

Regulation 3: Statement of purpose

The service being delivered to residents was observed to be in keeping with the centre's current statement of purpose dated January 2019. The statement of purpose contained all of the information as required by Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

A sample of incidents and accidents were reviewed and the inspectors found that all incidents were notified to the Office of the Chief Inspector as required by the Regulations.

Judgment: Compliant

Regulation 4: Written policies and procedures

The policies on the Provision of Behavioural Support and Staff Training and Development required review as the review period had exceeded three years. This had been self identified by the provider.

Judgment: Substantially compliant

Regulation 15: Staffing

There was an appropriate number and skill mix of staff to meet the assessed needs of the residents. However, there was a reliance on agency and relief staff which did not ensure the continuity of care and support for residents.

In addition, improvements were required in the maintenance of a planned and actual staff rota which includes full names of all staff working within the centre.

Staff files required review as the information and documents as required by Schedule 2 of the regulations were not in place for all files reviewed.

Judgment: Not compliant

Quality and safety

Overall, the inspectors found that the quality and safety of the service provided to the residents was good. However, improvements were required in the assessment of need, fire safety management, risk management and medication management.

The inspectors completed a walk-through of the centre and found that the house was homely and well maintained. The centre was a two storey house which consisted of two living rooms, kitchen/dining area, conservatory, a staff sleep over room, two bathrooms and five individual bedrooms (two of which were en-suite). There was a garden to the rear of the centre which contained an ancillary building which consisted of an office, utility room and snoozelene room.

Inspectors reviewed a sample of residents' personal files and found that an up-to-date assessment of need had been completed for each resident. However, the inspectors found that the assessment of need was not comprehensive as it did not

suitably identify all of the residents' needs in order to inform residents' personal support plans. It was identified that there were gaps in the documentation available regarding the assessments of need and personal plans for residents. Reviews of personal plans did not take into account the effectiveness of the plan or reflect changes in the residents' needs.

There were health care and social support plans in place to guide staff in supporting residents. Residents were supported to achieve their best possible health and had access to allied health care professionals as required.

Residents were involved in activities appropriate to their interests and preferences such as attending a local gym, community social club, shopping and dining out. Three of the four residents were engaged in local day services. One resident had not been able to attend a day service for 21 months. The centre manager informed inspectors that the resident was supported to engage in meaningful daytime activities with an individualised programme of support. The provider was in the process of developing an individualised day service which would be available shortly.

Overall, the provider had effective systems in place to ensure residents were safeguarded from abuse. Staff spoken with were knowledgeable on what constituted abuse and what to do in the event of a concern or allegation. Residents informed inspectors that they felt safe and were observed to appear comfortable and content in their home throughout the inspection. Positive behaviour support plans were in place for residents where required. Inspectors reviewed a sample of these plans and found that they were up-to-date and guided staff to support residents. A system to review restrictive practices was in place. However, not all potential restrictive practices used in the centre had been identified as such and reviewed.

There were arrangements in place for the assessment, management and ongoing review of risk but some improvement was required. The previous inspection identified that the risk management policy did not contain all of the information as required by Regulation 26. While the policy was reviewed, the inspectors found that this was not fully addressed. The provider maintained a risk register which was up-to-date and outlined individual and service risks and the controls in place to manage these risks. However, the risk register did not accurately identify and reflect all risks within the centre.

There were systems in place for fire safety management. The provider had suitable fire equipment in place including a fire alarm, emergency lighting and fire extinguishers. The inspectors identified that improvements were required regarding the containment of fire as fire doors were not in place as appropriate throughout the building. Regular fire evacuation drills had also occurred and of the sample reviewed they demonstrated residents could be evacuated in a timely manner. However, no simulated night time drill had been completed in 2018. Personal Emergency Evacuation Plans (PEEPs) were in place for each resident however, some additional information was required to ensure that staff were appropriately guided to safely support and evacuate the residents in the event of a fire.

The inspectors reviewed medication storage facilities in the centre and found that a number of medications did not contain expiry dates (including both blister packed and non-blister packed medication). There was a lack of clarity with regards to PRN medications (medications administered as the need arises). In some cases where PRN medications were prescribed, there was an absence of listed criteria for administration and the maximum dose to be administered in a 24 hour period. Staff members spoken with demonstrated appropriate knowledge of what actions to take in the event of a medication error occurring. There were assessments completed for all residents for the self-administration of medications and records of these assessments were maintained in the centre.

Regulation 17: Premises

The premises was decorated in a homely manner and was well maintained.

Judgment: Compliant

Regulation 26: Risk management procedures

The risk management policy did not contain all of the information as required by Regulation 26. These included:

- the measures and actions in place to control accidental injury to residents, visitors and staff;
- arrangements for learning from serious incidents, and
- arrangements to ensure risk control measures were proportionate to the risk identified.

The provider maintained a risk register which was up-to-date and outlined individual and service risks and the controls in place to manage these risks. However, the risk register did not accurately identify and reflect all risks within the centre.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had suitable fire equipment in place including a fire alarm, emergency lighting and fire extinguishers.

The inspectors identified that improvements were required regarding the containment of fire as fire doors were not in place as appropriate throughout the

building.

Regular fire evacuation drills had also occurred and of the sample reviewed they demonstrated residents could be evacuated in a timely manner. However, no simulated night time drill had been completed in 2018.

Personal Emergency Evacuation Plans (PEEPs) were in place for each resident however, some additional information was required to ensure that staff were appropriately guided to safely support and evacuate the residents in the event of a fire.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

There was no expiry dates available for some medications stored in the medication cabinet. There was a lack of clarity with regards to PRN medications. In some cases where PRN medications were prescribed, there was an absence of listed criteria for administration and the maximum dose to be administered in a 24 hour period.

Judgment: Not compliant

Regulation 6: Health care

There were health care plans in place which guided staff in supporting residents experience their best possible health. Residents were supported in accessing allied health care professionals as required.

Judgment: Compliant

Regulation 8: Protection

Residents were safeguarded from abuse. Staff spoken with were knowledgeable on what constituted abuse and what to do in the event of a concern or allegation. Residents informed inspectors that they felt safe and were observed to appear comfortable and content in their home throughout the inspection.

Judgment: Compliant

Regulation 7: Positive behavioural support

Positive behaviour support plans were in place for residents where required. Inspectors reviewed a sample of these plans and found that they were up-to-date and guided staff to support residents. A system for review of restrictive practices was in place. However, not all potential restrictive practices used in the centre had been identified as such and reviewed.

Judgment: Substantially compliant

Regulation 13: General welfare and development

Residents were involved in activities appropriate to their interests and preferences such as attending a local gym, community social club, shopping and dining out. Three of the residents supported by the centre had access to a day service and one resident was being supported to engage in meaningful daytime activities with an individualised programme of support while alternative arrangements were being developed.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

There were up-to-date assessment of needs in place for each resident. However, the assessment of need was not comprehensive as it did not suitably identify all of the residents' needs in order to inform residents' personal support plans. It was identified that there were gaps in the documentation available regarding the assessments of need and personal plans for residents. Personal Support Plans were in place for health and social needs. In addition, reviews of personal plans did not take into account the effectiveness of the plan or reflect changes in the residents' needs.

Judgment: Not 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 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Regulation 15: Staffing	Not compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 13: General welfare and development	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant

Compliance Plan for Navan Adult Residential Service OSV-0002674

Inspection ID: MON-0022489

Date of inspection: 16/01/2019

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 16: Training and staff development</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• All mandatory training for new staff have been scheduled. This training will be completed 25/02/2019

• Training records was reviewed by training department and PIC to ensure all required training has been scheduled. This was completed 17/01/2019.</td></tr>
<tr><td>Regulation 23: Governance and management</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Going forward an additional checking system will be implemented for ensuring the six monthly internal audits take place within the six month timeframe. An internal audit took place took place on 13th February 2019 which was within the six period since the last visit. Complete

• Going forward the internal six monthly visits and annual reviews along with the ongoing oversight from the PIC and PPIM systems will identify and monitor any non-compliances in the service including the monitoring the implementation of this action plan.</td></tr>
<tr><td>Regulation 4: Written policies and procedures</td><td>Substantially Compliant</td></tr>
</table>

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: • All organisational Schedule Policies 5 that are overdue review will be reviewed and circulated to guide staff practice by 31/03/2019.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Review of Rota has been completed, a legend key has been added to indicate the shift pattern on planned and actual Rota. Completed 18/01/2019 • Names of all staff including relief and agency staff are now included on Rota. Completed 18/01/19. • An audit of HR files for all staff employed in the service has been completed to ensure any Schedule 2 documents that are not in place are identified. All documents that can obtained will be secured and available for inspection in the service. 15/3/2019	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The Risk Register for the service will be reviewed to ensure all significant risks in the service are accurately identified and represented on the risk register. This will be completed by 15/03/2019. • Appendix 3 of the organisation's Risk Management Policy will be updated to reflect the gaps in the current policy identified through this inspection, this will be completed by 8/05/2019.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • Evacuation drill including all residents with the minimum compliment of staff (2) was completed on 17/1/2019. Complete • Individual PEEPS have been reviewed, additional information for nighttime evacuation has been added this was completed on 7/2/2019. Complete • Fire Expert visited the service on 18/02/2019. It was confirmed the doors in the service meet the requirements of the regulations at the time the building was opened as a residential service, there has been no adaptations to the service in the interim period. We are currently awaiting the report. This will be completed by 15/03/2019	

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• Review of dispensing PRN has been completed. Paracetamol now to be received into the service in packs with expiry date on the packet, paracetamol will no longer be accepted into the service in tubs. Completed 18/01/19

• PRN protocols have been reviewed with the indication of use shown on the DAR as per prescription such example paracetamol 500mg – 1000mg 4-6 hourly for pain or fever. Max dose 8 tablets (4 grams) in 24 hours. Completed 22/01/19

• Regular medications are dispensed in Blister packs to the service and are used within 4 weeks.

• The PIC will meet with the Pharmacist who dispenses medication for the service to discuss the findings of this report in respect of expiry dates on blister packed medication. This will be completed by 08/05/2019.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
All existing and potential Restrictive Practices have been identified in the service. These will be reviewed and signed off as required in line with organizational policy by 15/03/2019

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
• Meeting took place 31/01/2019 with the identified day service provider to review plans and determine next steps to move forward, it was agreed a further meeting is required with HSE as initial plan was not sufficient to meet resident's needs.

• Meeting with HSE to review day service placement took place on 06/02/2019.
The plan identified the service users need for 2:1 support due to behaviours that challenge and the difficulties experienced in busy environments. Currently awaiting on the HSE to advice on when the service will progress.

• In the interim daytime support will continue to be provided by the residential service.

Regulation 5: Individual assessment	Not Compliant

and personal plan	

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

• The annual needs screening for each resident will be reviewed and updated with additional detail to reflect input and recommendations from MDT supports as applicable. This will be completed by 15/05/2019.

• An additional needs assessment will be completed in addition to the existing needs screening to ensure all needs are identified and appropriate supports provided. This will be completed by 15/05/2019.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Orange	30/06/2019
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.	Substantially Compliant	Yellow	30/06/2019
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Not Compliant	Orange	18/01/2019

Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	15/03/2019
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	25/02/2019
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.	Not Compliant	Orange	13/02/2019
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the	Substantially Compliant	Yellow	13/02/2019

	chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
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 risks: accidental injury to residents, visitors or staff.	Not Compliant	Orange	08/05/2019
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Not Compliant	Orange	08/05/2019
Regulation 26(1)(e)	The registered provider shall ensure that the risk management	Not Compliant	Orange	08/05/2019

	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, 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.	Substantially Compliant	Yellow	15/03/2019
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	15/03/2019
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	07/02/2019

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	22/01/2019
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.	Substantially Compliant	Yellow	31/03/2019
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	Not Compliant	Orange	15/05/2019

	out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
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 effectiveness of the plan.	Not Compliant	Orange	15/05/2019
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	15/03/2019