Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of designated centre:	St Lukes and St Matthews
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Louth
Type of inspection:	Unannounced
Date of inspection:	20 March 2019
Centre ID:	OSV-0003013
Fieldwork ID:	MON-0025646

About the designated centre

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

St Luke's and St Mathews comprises of two units, located on a campus based setting in Co. Louth. The centre is registered for nine adults. The units are within walking distance of each other. One of the units supports four male adults. There is also a self-contained living area in this unit where one resident is supported during the day. The other unit currently supports three male adults. Staffing levels comprise of seven staff during the day and four staff at night. The skill mix comprises of nurses and health care assistants. A nurse is assigned to each unit during the day and one nurse is assigned between both units at night time. This nurse is allocated based on the particular needs of the residents.

Residents do not attend any formalised day services. They are supported by staff in the centre to have meaningful day activities during the day. There are two buses available in the centre for residents to access community activities. Some residents also avail of complimentary therapy sessions in the centre. The person in charge is responsible for three other centres under this provider. They are supported in their role in this centre by a clinic nurse manager who is assigned 12 hours supernumerary hours to ensure effective oversight of the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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
20 March 2019	14:30hrs to 19:15hrs	Anna Doyle	Lead
21 March 2019	09:30hrs to 14:30hrs	Anna Doyle	Lead

Views of people who use the service

The residents in this centre were unable to communicate their views on the quality of services being provided in the centre. The inspector observed that residents appeared content and looked well cared for.

They appeared relaxed in the presence of staff and were observed being engaged in some activities of their choice over the course of the inspection.

Capacity and capability

Overall the inspector found that improvements had been made to some of the services being provided in the centre since the last inspection. However, significant improvements were still required in a number of the regulations inspected in order to ensure a safe quality service for residents.

The provider has committed to transition residents to community based homes and close this centre by 2021. At the time of this inspection there had been no further progress on these transitions as the provider was prioritising other areas of the campus first. The inspector was assured from talking to the director of care and support who is a person participating in the management of the centre that this planned closure date is still set for 2021.

The provider had not ensured that the staff resource was appropriately managed and aligned to residents' needs. The staffing arrangements in the centre required review in order to ensure that residents needs were being met and that the staffing levels were appropriate to meet those needs at all times. A number of issues were identified and while most of them had been raised as concerns through audits, managers meetings and staff meetings, these issues had not been fully addressed at the time of this inspection.

The inspector found that, residents could not avail of off site activities between the hours of 12pm and 4pm everyday as staff lunch breaks had to be facilitated. There had been an over reliance on agency/relief staff over the last number of months due to staff vacancies and planned/unplanned leave. Some days there was not enough agency/ relief staff to cover shifts which resulted in staffing levels being below the assessed needs of the residents and also resulted in only one staff nurse being on duty which also impacted on some residents accessing community facilities.

It was also observed on the day of the inspection that during lunch breaks in one unit there was insufficient staff in place to meet the assessed needs of the residents

and there was no effective system in place for staff to seek support from other locations during this period should the need arise. For example; all of the residents in this location were assessed as requiring one to one support. Yet only two staff were present in the location. Staff were required to seek support if required from other areas and these supports were not available when requested by staff on the day of the inspection.

In response, to this the inspector met with the director of care and support who implemented a staffing protocol going forward to assure that residents were safe in the centre until such time that staffing arrangements could be fully reviewed.

There was a defined management structure in the centre. The person in charge reported to the director of care and support who in turn reported to the regional director.There was also a clinic nurse manager in the centre who reported to the person in charge and had oversight over the care being provided in the centre. However, given the issues identified at this inspection, which were also reflected in the high number of non compliance, the inspector found that the governance and management arrangements were not effective.

The provider had systems in place to audit the quality of care being provided in order to identify compliance or areas for improvement. The six monthly unannounced quality and safety review had been completed. This report was in draft format at the time of the inspection. Areas of improvement had been identified after this review and the inspector found that some of these actions had been addressed. For example; it was recommended that incidents relating to behaviours of concern should be reviewed and the inspector found that this was now being done.

All recommendations from audits were compiled on a quality enhancement plan for the centre. However, areas for improvement were not consistently responded to in order to address them.

The director of care and support met the person in charge to discuss the designated centre on a regular basis (this included discussing the quality enhancement plan). However, these meetings were not comprehensively recorded and therefore actions agreed to improve care were not evident. This meeting was also considered supervision for the person in charge and the inspector found that this was not adequate.

Staff who were met on the day of inspection demonstrated a good knowledge of the residents' needs in the centre and responded to their needs in a respectful manner over the course of the inspection. From a review of training records, all staff have completed mandatory training in manual handling, fire safety and safeguarding vulnerable adults. Other training provided included training in basic life support and positive behaviour support. Training had also been scheduled for staff to complete refresher training where required. However, some staff had not completed training in dysphagia and the management of epilepsy in order to support residents' needs in the centre.

Staff who were met informed the inspector that supervision meetings had taken

place for them. They gave examples of how changes were brought about when they raised a concern at these meetings to the person in charge or the clinic nurse manager.

Staff meetings were being held in the centre as a means of ensuring the team were informed and had up to date information. However, the attendance at these was poor. For example; at one staff meeting only six staff had been present. The inspector was informed that this was as a result of staff being on their days off. The minutes of the meetings viewed were also not comprehensive and actions agreed were not always implemented. For example; it had been agreed at a meeting in January 2019 to update the induction process for new staff to include safe guarding issues in the centre, this had not been completed.

Where residents had moved out and transitioned away from the centre, the provider had ensured that this was done in a planned and meaningful way. Some residents had transitioned to the centre since the last inspection and some residents had been discharged to their new home in the community. The inspector viewed one resident's personal plan and found that the resident had been supported with this transition. For example; they had visited the unit on several occasions, a staff member who knew the resident well also moved to the centre to work there (this provided consistency for the resident).

Members of the 'transforming lives committee' (who oversee all transitions) had also completed a review of this resident's move to their new home. The findings of this review indicated positive outcomes for the resident. For example; the resident was now living with peers who were near their own age profile and was interacting well with other residents in the centre.

Regulation 15: Staffing

Staffing arrangements and management of the staffing resource required review in order to facilitate support for residents with activities outside of the centre.

There was insufficient staff in place to meet the assessed needs of the residents during staff breaks and there was no effective protocol in place for staff to seek support during this period.

There had been an over reliance on agency/relief staff over the last number of months due to staff vacancies and planned/unplanned leave. This did not support

consistency of care.

Some days there was not enough agency/ relief staff to cover shifts which resulted in staffing levels being below the assessed needs of the residents and resulted in only one staff nurse being on duty which impacted on some residents accessing community facilities.

Judgment: Not compliant

Regulation 16: Training and staff development

Some staff had not completed training in dysphagia and the management of epilepsy which was required training in this centre.

Judgment: Substantially compliant

Regulation 19: Directory of residents

A directory of residents was maintained in the centre.

Judgment: Compliant

Regulation 23: Governance and management

The designated centre was not resourced to ensure the effective delivery of care and support; as residents did not have access to appropriate recreational activities and the staff arrangements were not sufficient to meet the needs of the residents in the centre at all times.

The supervision arrangements in place for the person in charge required improvement.

Staff meetings, which were used as a mechanism to keep the staff team informed, were not comprehensively recorded and staff attendance was poor at these.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The inspector was satisfied that residents had been supported to visit the centre prior to their admission to the centre and that the provider had ensured that this transition was being reviewed.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector was satisfied that the provider representative and the person in charge had notified HIQA of any adverse incidents in the centre as required under the regulations.

Judgment: Compliant

Quality and safety

Overall the inspector found that the provider had not sufficiently prioritised the safety and quality of care provided to residents while they continued living in this centre. The actions in relation to premises, identified for improvement at the last inspection, had not progressed in a timely manner and significant improvements were required in residents' access to recreational activities. Risk management processes also required improvement.

From a walk around of the centre the inspector observed that the provider was addressing the issues from the last inspection in that some improvements had been made to the premises. The premises were for the most part clean and some furnishings/ soft furnishings had been purchased to make it more homely. However, one area of the centre had not been prioritised or addressed and this was resulting in one resident's living area being not homely, poorly maintained and not accessible. The director of care and support took immediate actions to address this by the end of the inspection and submitted a written account of what improvements would be addressed and within a specified time frame to HIQA.

Other areas of the centre that required improvements since the last inspection were being completed in line with the action plan from the last inspection. This included the outside decking area for one unit which was not accessible to residents which was due to be completed by the end of March 2019.

Residents were being supported to avail of some activities in the community and on

the campus (although as already stated this was impacted by staff breaks). For example; on the day some residents were out for coffee and one resident was out for lunch. However, the inspector found that access to community and campus based activities was limited for residents. For example; one resident could not access the sensory room in accordance with their assessed needs. There was limited activities provided on the campus for residents to engage in. The inspector was informed that residents had access to gong therapy, arts and crafts and some complimentary therapies. However, some residents could not access gong therapy and other residents had not expressed an interest in arts and crafts activities.

Some areas of good practice were identified. Residents had personal plans in place which included an assessment of need. From a sample viewed the inspector found that there were comprehensive care plans in place to support residents with their health care needs. These plans were being reviewed every three months or sooner if there was a change in need. An audit system of personal plans was also conducted to ensure that records were up to date. The inspector found that areas of improvement from one audit conducted had been addressed.

Residents had access to a GP and other allied health professionals and had been supported to access health screening services in line with best practice. However, improvements were required in one plan viewed. This resident had a sensory assessment completed in June 2018 and there was no report compiled for this in order to inform staff practice.

Residents were being supported to achieve personal goals. For example; one resident was being supported to improve their skills using an electronic tablet. Another resident was being supported to visit a bee keeper as they were interested in nature.

Good practice was also observed in relation to the positive behaviour support provided to residents. Staff had completed training in positive behaviour support. Staff spoken to were aware of the specific support needs of the residents. The inspector observed one residents behaviour support plan and found that it had recently been updated. The clinic nurse manager showed the inspector a new review system that had been implemented recently to support residents and to ensure that the least restrictive measures were being implemented. For example; when residents required the use of prescribed chemical restraint, this would be reviewed and documented each time in order to understand what caused the behaviour and if the response to this behaviour was appropriate or required alternative interventions by staff.

The inspector also found that one environmental restriction had been removed as part of ongoing efforts to reduce restrictions. Another resident had a physical restriction reduced. This was being conducted on a phased basis. Staff reported that this was having a positive impact on the residents quality of life as some adverse incidents had reduced for this resident as a result of this. There was effective oversight of restrictive practices as all practices were approved and reviewed by a senior management committee and the residents representative. Records were also

maintained of when restrictions were implemented.

All staff had completed training in safeguarding vulnerable adults. Safeguarding plans had been put in place in response to some safeguarding concerns which related to the impact of behaviours of concern on some residents. These incidents had been notified to HIQA. Staff were aware of these plans which had been reviewed by the staff team to assess their effectiveness. Residents had intimate care plans in place and from a sample viewed they were found to contain comprehensive information about the needs of the residents in order to support them.

Risk management systems in the centre required review. For example, one resident had a risk assessment in place in relation to their environment being unsafe and while staff had reported the identified control measures in order to make it safe to the appropriate personnel, this had not been addressed. In addition, there was no system in place to review and identify trends from all adverse incidents that occurred in the centre. The inspector was informed that this was reviewed with all staff at staff meetings. However, as already stated in this report these meetings were poorly attended and therefore it was not clear how learning was being implemented or how staff were informed of this learning.

The inspector acknowledges that the provider was implementing new risk management systems in the centre (and the wider organisation) at the time of this inspection.

Regulation 13: General welfare and development

Residents did not have sufficient access to recreational activities on the campus. Access to community activities was also limited by the staffing arrangements in the centre.

Judgment: Not compliant

Regulation 17: Premises

One area of the premises required significant improvements in order to ensure that it was homely, accessible to the resident and well maintained.

Other areas of the centre that required improvements since the last inspection were being completed in line with the action plan from the last inspection. This included the outside decking area for one unit.

Judgment: Not compliant

Regulation 26: Risk management procedures

One resident had a risk assessment in place in relation to their environment being unsafe and while staff had reported the identified control measures in order to make it safe to the appropriate personnel, this had not been addressed.

There was no system in place to review and identify trends from all adverse incidents that occurred in the centre. The inspector was informed that this was reviewed with all staff at staff meetings. However, as already stated in this report these meetings were poorly attended and therefore it was not clear how learning was being implemented or how staff were informed of this learning.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

For the most part residents had personal plans in place which were up to date and informative. There was also evidence of residents being supported to achieve their identified goals.

There was no report available for one resident who had a sensory assessment completed in June 2018 in order to inform staff practice.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were being supported to enjoy good health. They had access to allied health professionals where required and had an annual review their GP.

There were comprehensive care plans in place to support residents with their health care needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

All staff had completed training in positive behaviour support. One new staff was scheduled to complete this in the coming months. The inspector observed one residents behaviour support plan and found that it had recently been updated. Staff met were aware of the residents support needs.

There were effective systems in place to manage and review the use of restrictive practices in the centre.

Judgment: Compliant

Regulation 8: Protection

All staff had completed training in safeguarding vulnerable adults. Safeguarding plans had been put in place in response to some safeguarding concerns(which related to the impact of behaviours of concern on some residents) and had been notified to HIQA.

Staff were aware of these plans and the plans had been reviewed by the staff team to assess their effectiveness.

Residents had intimate care plans in place and a sample viewed were found to contain comprehensive information about the needs of the residents in order to support them.

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 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for St Lukes and St Matthews OSV-0003013

Inspection ID: MON-0025646

Date of inspection: 21/03/2019

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: 1. Residents' assessed needs have been reviewed and plans of care have been adjusted to reflect their changed needs. 2. Staffing rota will be reviewed by management so that residents can be supported to engage in meaningful activities throughout the day. 3. Additional Staff hours (as Required) have been approved to support residents who wish to engage in community activities that might otherwise be impacted by staff meal breaks (i.e 12pm to 3pm) 4. Management team met on Tuesday 26/03/19 and a Standard Operation Procedure was devised to manage Lunch Breaks.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. The five staff requiring Dysphagia training will complete same online using HSE Land. 2. There is 24hr nursing care provided within the DC, and there are adequate numbers of staff trained to deliver emergency medication for epilepsy (in the absence of a registered nurse) while engaging in activities off campus.	

3. Remaining six HCAs that require Epilepsy and Buccal training have been booked to receive training.

4. All HCAs know the residents presentation pre seizure (Aura) activity and immediately contact the RN on duty

5. When residents who have epilepsy are availing of off campus activities they are either supported to do so by a RN or a familiar HCA who has received Epilepsy & Buccal training

Regulation 23: Governance and management	Not Compliant

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

1. Staffing rota will be reviewed by management so that residents can be supported to engage in meaningful activities throughout the day.

2. Residents' assessed needs have been reviewed and plans of care have been adjusted to reflect their changed needs.

3. The Director of Care and Support conducts informal supervision with the PIC on a weekly basis, in addition to regular formal sessions.

4. A new template is being used to record team meetings and staff attendance will be rostered.

5. On call staff members who are familiar to the DC are sought first to fill any needs.

6. On call staff receive all mandatory training on induction to the service and receive refresher training as required.

7. On call staff members receive a morning handover when they commence duty from RN on completing night duty.

8. Familiar on call and agency staff are utilised to the needs on planned rosters.

9. Agency staff have completed all mandatory training prior to covering shifts within the DC as per requirements of Agency

10. All on call and agency staff receive an induction completed by RN on duty on the first day of duty.

11. Senior management are currently reviewing staffing levels within the service with view of reallocation to areas with high usage of on call and agency staff.

12. Management is trying to recruit to permanent vacancies, recruiting to maternity leave cover is more problematic.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
1. Staffing rota will be reviewed by management so that residents can be supported to engage in meaningful activities throughout the day.

2. A detailed review of all residents social and recreational activities (community and on campus) commensurate with their interests, preferences and capacities, will be carried out, to inform the development of new individualised opportunities and programmes.
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Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. The area specifically referenced in the report has been appropriately decorated.

2. The schedule of works previously submitted continues to form the basis for the ongoing development/decoration of the centre.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. Urgent maintenance issues highlighted to maintenance supervisor
To be rectified within a timely manner.

2. Incident review system in place and is reviewed monthly by Management, team informed of incidents and trends at team meetings, staff members will be rostered for team meetings.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: 1. Allied Health professional to agree an appropriate timeframe within which formal reports and recommendations will be provided to key workers.

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(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	30/06/2019
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of	Not Compliant	Orange	30/06/2019

	residents, it is provided.			
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	30/06/2019
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.	Substantially Compliant	Yellow	30/06/2019
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	31/12/2019
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.	Not Compliant	Orange	31/12/2019

Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	30/06/2019
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		30/06/2019
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	30/06/2019
Regulation 26(2)	The registered provider shall ensure that there are systems in	Not Compliant	Orange	30/05/2019

	place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	20/05/2019