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:	Walk C
Name of provider:	Walkinstown Association For People With An Intellectual Disability CLG
Address of centre:	Dublin 12
Type of inspection:	Unannounced
Date of inspection:	04 December 2018
Centre ID:	OSV-0003406
Fieldwork ID:	MON-0025467

About the designated centre

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

Walk C comprises three residential services and aims to support residents to live socially inclusive lives. Two of the houses in the centre aim to deliver a service for those with dementia.The needs of each person are individual and are captured in detail in their care plan. Staff are trained to support each person living in the house and ensure the identified goals in the care plan are being worked on. The houses are equipped with individual bedrooms, shared kitchen, living and dining spaces, bathrooms and gardens. There is access to the local community and leisure facilities such as pubs, cafés, fitness centers and churches.

The following information outlines some additional data on this centre.

Current registration end date:	12/10/2019
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
04 December 2018	09:00hrs to 17:30hrs	Amy McGrath	Lead
04 December 2018	09:00hrs to 17:30hrs	Michelle McDonnell	Support

Views of people who use the service

Inspectors met with four of the residents who use the service. Three of the residents shared their home, and the fourth lived alone.

Residents appeared comfortable in their homes, and welcomed the inspectors, showing them around their houses. Inspectors observed that interactions between staff and residents were respectful, considerate and responsive. One resident spoke with inspectors and stated they were very happy living in their home, and liked having visitors over. Another resident spoken with discussed how long they had lived there, and expressed that they liked the staff and felt they were being supported well.

Capacity and capability

The governance and management arrangements required improvement to ensure that residents consistently received a service that was safe and of good quality. While residents spoken with informed inspectors that they were happy in their homes, the oversight mechanisms, particularly in relation to information governance, required significant improvement to facilitate effective monitoring of the service. Further improvement was required in relation to auditing arrangements, and the contracts of care required addressing to ensure compliance in this area. Some strengths were observed, such as sufficient staffing levels and a well trained workforce.

The centre was managed by a person in charge, who reported to a director of services, and inspectors found that there were clear lines of authority and accountability within the management structure. The person in charge supervised a team of social care workers, who were suitably qualified and experienced to meet the assessed needs of residents. Where residents required nursing support, this was accessed through the public health system, or attended to by the organisation's own health care coordinator, who was a registered nurse.

Staff had received all mandatory training, and there was a schedule of refresher training in place. Additional training, specific to residents' support needs, had also been made available to staff. The provider had obtained all of the information required by Schedule 2 in relation to staff (such as a Garda vetting declaration and references).

While there were arrangements in place to facilitate oversight of the quality and safety of the service, these systems required improvement. The provider had carried

out a comprehensive annual review and prepared a report on quality and safety, which identified some areas for improvement as well as a clear action plan. While the provider had carried out unannounced visits to the units within the centre, these had not been carried out on a six monthly basis, and did not inform a report on the quality and safety of care and support provided in the centre as a whole.

Throughout the course of the inspection, it was found that significant improvement was required in relation to record and document management. The provider had implemented an electronic record management system, that was inconsistently utilised, and inspectors found that the arrangements in place did not facilitate staff to exercise their professional responsibilities for the quality and safety of the service they were delivering. For example, staff found it difficult to locate up-to-date documents when requested throughout the inspection; active paper files contained older documents such as risk assessments, personal evacuation plans and financial support plans, which were found to be no longer in use, and at times staff were unclear which support plan was in use. Furthermore, safeguarding plans were not accessible to staff who were responsible for the day to day care and support of residents, and were held in a drive accessible by the person in charge. These arrangements did not facilitate consistent delivery of safe and quality care to residents.

Further improvement was also required in recording systems relating to risk management, to ensure that emergent risks were identified promptly and to facilitate an effective review of risk management mechanisms within the centre. This is described in greater detail later in the report.

The support needs of some residents could no longer be appropriately met in one unit of the centre due to advancing changing needs, although the provider had demonstrated responsiveness by minimising the risks associated with this, and planning for alternative appropriate arrangements.

Each resident had a contract of care in place, however these required clearer detail of the fees to be charged to residents.

The provider had prepared in writing and adopted most of the policies and procedures set out in Schedule 5 of the regulations, however there was no visitors policy in place. All policies had been reviewed and updated within an appropriate time frame.

Regulation 15: Staffing

There were sufficient staff, who were suitably skilled and experienced to meet the needs of residents. The provider had demonstrated responsiveness to changing needs of residents by adapting staffing levels as required. There was an actual and planned roster that was maintained by the person in charge.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had received all mandatory training, as well as additional training specific to the support needs of resident. The person in charge had ensured that copies of the Act and the regulations were made available to staff.

Judgment: Compliant

Regulation 23: Governance and management

There were clear lines of authority and accountability, within defined roles and responsibilities, however the arrangements in relation to information governance did not facilitate effective oversight. Improvements were required to the records management system to support staff to exercise their professional responsibilities, for example, staff did not have access to the most up to date support plans for residents.

The provider had carried out a comprehensive annual review of the quality and safety of the service, however had not conducted six monthly unannounced visits to the centre as required by the regulations.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The contracts of care did not include detail of the fees to be charged to residents, this was an outstanding action from the previous inspection.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The provider had prepared and adopted most of the policies and procedures as outlined in Schedule 5 of the regulations, however there was no visitors policy in place.

Judgment: Substantially compliant

Quality and safety

For the most part, residents were happy, safe and receiving a person centred service. In some cases, unsuitable living arrangements, which had developed due to the changing needs of residents, had impacted on the quality of life for some people. These issues had been identified by the provider and there were short term control measures in place to minimise associated risks. The provider had engaged with appropriate allied health professionals and external agencies to begin planning for a more long term solution to meet the needs of residents in a person centred manner.

The provider had ensured that residents' general welfare and health care needs were well supported. There were improvements required to the management of risk and safeguarding arrangements. The person in charge had not ensured that there were appropriate and suitable practices in place in relation to the prescribing, storage, disposal or administration of medicines. In some units the premises required minor maintenance and decoration, and in one case the premises no longer met the needs of one resident; this is discussed later in the report. The provider had satisfactorily responded to actions from the previous inspection in relation to emergency lighting.

The provider had ensured that residents' general welfare and development was supported in a person centered manner. Residents had access to a range opportunities for recreation and there was sufficient staffing to support residents in directing how they chose to spend their day. Residents were facilitated to develop and maintain personal support networks, and had visits from family members and friends.

Residents health care needs had been assessed, and there were supporting care plans in place for any identified need. Residents had access to a range of allied health professionals, and were supported to engage in health screening programmes where appropriate.

Residents had access to a pharmacist, and were supported by staff to manage their medications. There were secure storage arrangements in place, however medicines that had been discontinued were stored alongside current medicines without any indication that they were no longer in use. The inspector found medicines that were labelled with instructions that were contradictory to the prescription noted on the kardex (prescription records), for example, one medicines labelled instructions were to administer three times daily, however it was recorded on the kardex that this medicine was prescribed to be taken twice daily.

Inspectors found that there were no guidance documents in relation to the administration on PRN (medicines taken as the need arises) medication. There was

insufficient information and guidance for staff to safely and effectively administer medicines as required. For example, one resident had been prescribed two medicines with a common active ingredient, however there was no guidance to inform staff of which medicine should be administered, and for what indication should each be taken for. Residents' kardexes did not contain a date and therefore it could not be determined when they had last been reviewed. This was particularly concerning for residents who were using long term pain relief.

While there were arrangements in place to protect the safety of residents, for example, all staff had received mandatory training in safeguarding adults, the arrangements did not ensure a consistent and effective response to safeguarding concerns. While the provider had been responsive to concerns that came to their attention, and there were arrangements in place to protect residents from abuse, these arrangements had been established outside of the formal safeguarding process. For example, where concerns had been screened, and an interim safeguarding plan had been developed, this plan was not available to staff who had day to day responsibility for the care and safety of residents. The interim safeguarding plan was not guiding care practices, and could not be effectively reviewed for efficacy as per national policy.

Where residents required support to positively manage their behaviours, the provider had developed support plans with input from appropriate allied health professionals. The provider had made efforts to identify and alleviate cause of behaviours, and had engaged with numerous external agency to seek additional support and information in relation to supporting residents in this area. While there was minimal use of restrictive practices recorded, the inspectors found that restrictions were not being implemented with a clear evidence base. In some cases, restrictive procedures had been introduced, were in place for a period, and subsequently removed, without assessment or review. It was unclear what risk the restrictive practice was intended to control, and whether or not it was appropriate to remove it.

Similarly, the provider had some other arrangements in place to mitigate risk in the absence of a risk assessment. For example, the provider had not assessed the risk to residents in relation to the behaviour of other residents, which often impacted on their safety and quality of life, although had introduced control measures such as planned breaks from the centre. Some risk assessments that were viewed were no longer valid, and up to date versions for each of these were difficult to locate due to the document control systems in the centre. There was no centralised record of risk within the centre, with records of individual risks stored in each premises of the centre. This did not enable the person in charge to have effective oversight of risk management, to respond to emerging risks or to evaluate the effectiveness of control measures.

For the most part, residents were supported to maintain control and ownership of their possessions. They were facilitated to bring items of their own into their homes, and a log of personal possessions was maintained. Clarity was required with regard to residents purchasing household items (for example curtains), and who retained ownership of these items, as the residents' contracts of care were not clear with

regard to who was responsible for purchasing such items. Residents received support to manage their finances where required, and the provider had effective arrangements in place to ensure effective oversight of the management of residents' finances.

The premises, for the most part, were well maintained and in a good state of repair. One of the premises viewed by inspectors required some upkeep to ensure it was decorated in a suitable and homely manner, and some minor maintenance issues required attention, for example, mould stains were observed in a utility room. Another had been decorated in accordance with the residents preferences.

In one house, the size and layout of the premises no longer adequately met the needs of residents. The changing needs of residents meant that one small shared living space did not provide adequate private accommodation; residents were impacted regularly by the behaviour and presenting needs of each other. The provider had responded to the changing needs of residents by implementing control measures to minimise the risks associated with this, such as increased staffing and breaks away for residents, and had plans in place to identify alternative arrangements.

Regulation 12: Personal possessions

For the most part, the person in charge had ensured that residents retained control of their personal possessions, and residents were receiving support to manage their finances where necessary. However improvement was required to ensure that where residents purchased household items, the ownership of these items was recorded.

Judgment: Substantially compliant

Regulation 13: General welfare and development

Residents were supported to maximise personal development, and to develop and maintain natural support networks. They had access to facilities for occupation and recreation, and were active participants in their local communities.

Judgment: Compliant

Regulation 17: Premises

Generally the premises were in good condition and well maintained, however there were some areas for improvement such as mould stains in a utility room. The decoration of premises required improvement in one home. The design and layout of one of the premises within the centre did not adequately meet the support needs of residents.

Judgment: Not compliant

Regulation 26: Risk management procedures

There were risk management arrangements in place, however these were not effective in assessing and managing risks, or in evaluating the effectiveness of control measures. Furthermore, arrangements in place did not facilitate learning from incidents or identifying emergent risks.

Judgment: Not compliant

Regulation 28: Fire precautions

The inspectors reviewed the actions from the previous inspection and found that they had been adequately implemented. No other aspects of this regulation were reviewed during this inspection.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge had not ensured that there were appropriate and suitable practices in place in relation to the prescribing, storage, disposal or administration of medicines. Examples include:

- Medicines that had been discontinued were stored alongside regular use medicines, with no indication that they were no longer in use.
- Some prescriptions records contained administration instructions that were different to those printed on the label of medication.
- There was no PRN (medicine taken as the need arises) guidance to inform staff of how and when medicine should be administered.
- Prescription records did not contain a date of review.

Judgment: Not compliant

Regulation 6: Health care

The provider had ensured that residents received appropriate health care support. Residents health care needs had been assessed and support plans developed which incorporated recommendations from appropriate allied health professionals.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents behaviour support needs had been identified and there were support mechanisms in place. The registered provider had not ensured that the use of restrictive practices was evidence based and reviewed as part of the personal planning process.

Judgment: Substantially compliant

Regulation 8: Protection

While there were mechanisms in place to keep residents safe, and the provider demonstrated responsiveness to safeguarding concerns, not all incidents were investigated by the person in charge as per regulations.

Judgment: Substantially 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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Walk C OSV-0003406

Inspection ID: MON-0025467

Date of inspection: 04/12/2018

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
All houses in Walk C shall ensure that archiving for all out of date documentation is completed by 28th February 2019.

All keyworkers shall report to the Team Leader and Person in Charge all documentation is held electronically, confirm the filing and index system, confirm that all documentation and plans are current and up to date, provide a plan for updated any documentation that is required and a plan for documentation review in 2019 by end of 28th February 2019.

This information is communicated through the team meeting scheduled in February and March 2019.

Person in Charge audits the above actions and documents the outcome by 28th March 2019.

All unannounced audits in 2018 have been completed. Team leader and Person in Charge to review actions by 28th February 2019 and from there on in monthly during 1:1 meeting as the need arises.

Schedule for 2019 audits to be complete by 28th February 2019 and audit teams and format agreed.

Annual report for 2018 to use the new format to enhance learning.

Safeguarding Plans to be uploaded onto SharePoint and allow staff access by 28th February 2019.

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

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
Team leaders to review all Contract of Care for all people living in WALK C by 28th February 2019 against regulation.

Where Contracts do not comply with the regulation Team Leaders to confirm with Person in Charge agreed changes by 28th February 2019.

Where changes have been required communicate with the person supported and family/ representative where required by 29th March 2019.

Team Leaders to confirm in writing with Person in Charge all Contracts of Care are compliant with regulations by 29th March 2019.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
WALK to implement visitor's policy in residential houses by 30th August 2019.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
Person in Charge to ensure that when household items are purchased by the provider and when they are purchased by the individual is clarified in the Contract of Care by 28th February 2019.

Team Leaders to confirm that the Person Processions documentation in place and accurate for each person by 28th February 2019. If changes are required that an agreed timeframe is confirmed with the person in Charge.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Team Leader to immediately address mold in utility room in Dunmore Park – 28th February 2019

Person in Charge to audit all houses in WALK C against acceptable standards of cleanliness by 28th February 2019.

Person in Charge and Team Leader to review findings against documented cleaning plan to ensure that the plans are effective – make changes and communicate to staff teams as required – 29th March 2019.

Commence implementation of maintenance schedule for 2019 and continue to address maintenance issues as they arise through the agreed structure.

WALK have commenced construction on new building (Rafters Lane) which is planned will become a home to the people currently living in accommodation that does not meet their needs. This construction is scheduled to be completed in 30th August 2019 and planned moving date of 30th September 2019.

Commence discussion with HIQA on registration requirement for new development in 29th March 2019 to ensure that the registration process does not delay people move to new accommodation.

Continue discussion with HSE to ensure that there is adequate funding to support people living in Rafters Lane who are experiencing increasing needs associated with an aging population with intellectual disability.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
WALK C have commenced a review of the current risk management system that includes identifying documented risks on the electronic systems, risks that have been previous address in hard copy report but not updated in electronic system, controls that are implemented but do not have corresponding risk assessment completed and where risk

have resulted in any form of restriction that they are documented as such and reviewed through the Human Rights Enhancement Committee, a group that includes external representation. The Person in Charge is responsible for the completion of this actions and this stage is to be completed by 29th March 2019.

Based upon the above Person in Charge shall develop an action plan for all WALK C to ensure compliance and enhance the current system and commence implementation by 30th April 2019.

Based upon review outcome develop staff training and implantation through team meetings by 30th April 2019.

Person in charge to confirm full compliance in WALK C to the use of WALK Risk Management System and compliance with Regulation 26 by 31st May 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:
Team leader shall ensure that all medication that is discontinued to be returned by 31st January to the pharmacy – the team leader in each house shall confirm that this has been completed.

Team leader shall confirm medication disposal procedure is understood by all staff in WALK C through supervision and/ or team meeting in 28th February 2019.

Team leader shall confirm with all staff that stocktaking medication needs to take account of all medication on the premises and when this includes discontinued medication that it the staff member's responsibility to action this. This shall be completed in the above format.

Team Leader shall undertake a review of all medication to ensure that all medication labels correspond with Kardex information and action immediately any discrepancies.

Team leader shall confirm medication administration procedure with all staff and ensure that the teams attention is brought to the step whereby the medication label is confirmed with the Kardex by 28th February 2019.

Person in Charge and Team Leader shall review all PRN medication in 28th February 2019 to ensure that there is an appropriate administration criteria in place. Where required the Person in Charge and Team Leader will consult with GP and/ or Health care Coordinator by 29th March 2019.

Team Leader shall review all Kardex and ensure that each sections requiring information is complete by 28th February 2019.

Each keyworker shall consult with person GP at next appointment, or 30th April 2019 if no subsequent appointment, to confirm the need for a medication review and appropriate time frame.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
WALK C have commenced a review of the current risk management system that included identifying documented risks on the electronic systems, risks that have been previous address in hard copy report but not updated in electronic system, controls that are implemented but do not have corresponding risk assessment completed and where risk have resulted in any form of restriction that they are documented as such and reviewed through the Human Rights Enhancement Committee that includes external representation. The Person in Charge is responsible for the completion of this actions and this stage is to be completed by 29th March 2019.

Based upon the above Person in Charge shall develop an action plan for all WALK C to ensure compliance and enhance the current system and commence implementation by 30th April 2019.

Based upon review outcome develop staff training and implantation through team meetings by 30th April 2019.

Person in charge to confirm full compliance in WALK C to the use of WALK Risk Management System and compliance with Regulation 7 by 31st May 2019.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Person in Charge shall make contact with HSE Safeguarding team by 28th February 2019 with a view to meeting as soon as possible to agree procedure for instances of verbal aggression between residents with dementia diagnosis and where the risk is low can be captured and review by the service and reported on a quarterly basis as has been agreed in other areas of the service.

All other instances of alleged abuse shall continue to be reported as per national policy as is the current practice.

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Substantially Compliant	Yellow	28/02/2019
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	30/09/2019
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered	Not Compliant	Orange	28/02/2019

	provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the 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 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.	Not Compliant	Orange	29/03/2019
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the	Not Compliant	Orange	29/03/2019

	services to be provided for that resident and, where appropriate, the fees to be charged.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	31/05/2019
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	29/03/2019
Regulation 04(1)	The registered provider shall prepare in writing and adopt and implement policies and procedures on the matters set out	Substantially Compliant	Yellow	30/08/2019

	in Schedule 5.			
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Substantially Compliant	Yellow	31/05/2019
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	31/05/2019
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Substantially Compliant	Yellow	28/02/2019