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:	Ardnore
Name of provider:	S O S Kilkenny Company Limited by Guarantee
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	18 April 2019
Centre ID:	OSV-0003412
Fieldwork ID:	MON-0023363

About the designated centre

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

This centre comprises of three houses, and is home to eighteen residents. Each house is in close proximity to each other and accommodates six individuals. The houses that make up this centre are all close to local amenities and are on the outskirts of a large town. The centre provides community based living for adults with mild to moderate intellectual disability and is open seven days a week all year with no closures.
This centre aims to provide services that are person centered and that promote relationship building and social inclusion in the communities where the individuals live.

The following information outlines some additional data on this centre.

Current registration end date:	18/01/2021
Number of residents on the date of inspection:	18

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
18 April 2019	08:30hrs to 17:00hrs	Tanya Brady	Lead

Views of people who use the service

The inspector had the opportunity to meet with nine residents on the day of inspection. The other nine were either attending their day services or at home visiting with family for Easter. As this centre comprises of three separate houses the inspector ensured to meet with residents from each house.

In one house all six residents were present and happy to engage with the inspector despite many queries as to why there was a visitor in the house in the morning time. One individual reported that they like the fun they have in the house with friends and was observed laughing over a joke with another resident while they had a cup of tea together. While another reported that they are not happy all the time as they get annoyed when others make a mess and they were seen to engage with another resident over tidying the table after breakfast. Residents were observed by the inspector to spontaneously carry out activities in the house such as bringing in the bins or loading the dishwasher. The inspector was brought to the conservatory to see a framed photograph of a well known country music singer that had pride of place on the coffee table and his photograph was seen on a number of bedroom walls when the inspector was shown around. Another resident was packing to visit family for the weekend and was keen that the inspector see how organised they were and how well packed the suitcase was.

In another house there were two residents present. One had just returned from a night away in a hotel where they had stayed with support of staff and had met their sister for a meal, this resident wanted the staff to see the new clothes they had bought. A natural and animated discussion was observed about the newly purchased items and planning when they might be worn. They reported that they liked visiting but it was good to come home. Staff were observed using familiar routines such as setting the table to support the resident in transitioning back to their house while they were still excited about having been away. Another resident was sitting quietly in a small sitting room with a member of staff also present to chat with them and reported that they liked the peace when others were out and requested no television be put on.

In the third house one resident was present who spends a period of time independently during the day in the house. They were observed to be very relaxed in their environment and loud music was playing when the inspector arrived. The resident reports that they love music and when the others are not present they can turn up the volume. The resident warned the inspector that their bedroom was 'messy' and was keen that the inspector see their space so they could laugh about the room together. Staff were engaged in discussing increased storage specifically for the music CDs and DVDs that were in their room. The resident offered and made coffee and was encouraged by staff to be the host as it was their home.

Capacity and capability

Overall the inspector found that the registered provider and person in charge were striving to ensure a good quality and safe service for residents in this centre. Residents were supported to engage in meaningful activities and the additional presence of a team leader consistently throughout the centre ensured that a safe and effective service was afforded to the residents.

There were clearly defined management structures that identified the lines of authority and accountability. The registered provider had appointed a person in charge of this centre who had a number of governance responsibilities as part of their role as assistant director of services. As a result they were supported in their role in this centre by a team leader who had taken on a number of areas of responsibility such as auditing of systems and processes and direct supervision of staff; however there were frequent meetings between the person in charge and the team leader to ensure oversight of the services provided. These meetings covered residents' needs, individual plans, clinical supports, audits, safeguarding and other issues as they arose. The staff team reported to the team leader who in turn reported to the person in charge. The person in charge reports to the director of services.

The registered provider had systems in place to ensure there was an annual review of the quality and safety of care and six monthly unannounced visits by the provider or their representative. Actions identified as part of these reviews were clear, time bound and assigned to a named individual for completion. There was also a suite of audits in place that were carried out by the team leader and the findings reviewed by the person in charge. There was evidence of follow up on the actions arising from these audits, on the day of inspection some of these actions were actively being worked on. Staff meetings were held every four to six weeks and while usually they were house specific there was evidence that on occasion a centre wide staff meeting was scheduled, the most recent one focused on discussion of the findings from registered provider audits.

The registered provider had made arrangements to ensure there were adequate staffing levels to meet the assessed needs of the residents in two houses of this centre. In one house however residents needs were changing and staff report that there are times when there has to be an "all or nothing" approach to engaging in the community as there are not adequate staffing levels to facilitate an individual to go out without everyone having to go too. In addition within this house in the mornings due to residents evolving needs there was an acknowledged requirement to increase staffing levels to ensure safety of residents. The registered provider was currently reviewing staffing levels to minimise the impact on residents and reported that they are in the process of recruiting additional staff. An actual and planned rota

was developed and maintained by the team leader and was reviewed by the inspector.

Supervision of staff was implemented informally on a day to day basis and formally twice a year by the team leader who was based within the centre. The outcomes from these supervisions were discussed with the person in charge and there was clear oversight of the process. The team leader additionally received formal supervision from the person in charge on a regular basis and the registered provider facilitated them to access external professional support. Each staff member who spoke to the inspector was knowledgeable in relation to their residents care and support needs. Staff had completed training and refreshers in line with residents' needs. While two members of staff required refresher training the inspector observed that this was scheduled.

The registered provider had ensured there was a service provision agreement or contract between the organisation and the resident. While these were in place for all they had not been consistently reviewed when individual circumstances changed or when there was a change in fees to be incurred.

A centre specific complaints log was maintained by the team leader with clear documented evidence those complaints were dealt with in a timely and effective manner. A complaints policy was in place to guide staff and was available in an easy read manner for residents as requested. Details of the complaints officer and how to make a complaint was visible in all three of the houses and advocacy details were also displayed if required.

Regulation 15: Staffing

The inspector found that staff were suitably qualified and had the right skills to support residents. However due to residents changing needs the inspector noted there were not sufficient numbers of staff to meet the assessed needs of the residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The inspector found that staff had the required competencies to manage and deliver person-centred, safe and effective care and support for residents. They had access to training and refreshers and were in receipt of formal supervision and support from the team leader who was supported by the person in charge.

Judgment: Compliant

Regulation 23: Governance and management

A clear governance structure was in place along with auditing arrangements to monitor the service provided to residents. Unannounced visits and annual reviews of the care and support provided to residents were being carried out and these included a supporting action plan to respond to issues identified.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

The registered provider had ensured the development of a comprehensive service provision agreement between the registered provider and the resident. However this was not consistently updated for all residents when circumstances changed.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

A complaint policy was in place within the centre giving clear guidance to staff. The detail of the complaints officer was visible and accessible information on the process was available.

Judgment: Compliant

Quality and safety

Overall the residents in this centre were supported to engage in meaningful activities and to live a life of their choosing. The inspector reviewed the quality and safety of the service being provided and found good practice in a number of areas however some improvements were required to achieve and maintain a high level of compliance. Residents were seen to access a number of social activities such as sporting events, going on short breaks or day trips, going for coffee with family or staff or shopping and were supported to do so where possible. There was an emphasis on supporting individuals with life skills including independent access of public transport, looking after their home or managing their own money.

The premises was found to be clean, spacious and personalised with items and photographs important to residents on display. Minor cosmetic work and repairs were required in some of the houses, such as repairing holes in door frames where fixings were changed or filling and painting around replacement light fittings on ceilings. Two of the houses comprised of semi-detached properties combined into a single house. In one of these there was no access from one side to another upstairs, a single bathroom was on either side of the house upstairs, one with a shower and one with a bath, so individuals had to come down stairs cross through the house and up the stairs on the other side other side to access their preferred bathroom. In one of the houses the dining space was laid out with multiple small tables in rows similar to a canteen rather than a residential space.

The inspector reviewed a number of residents' personal plans and found them to be person-centred. Each resident had an assessment of need in place and care plans in place were in line with these assessments. The inspector found however that improvement was required in relation to the recording of goals, both social and functional. While it was apparent that residents were active in their community and supported in engaging with meaningful tasks these were not documented and as such it was not possible for the inspector to see whether reviews were occurring with the view of introducing an expanded range of activities if appropriate.

Residents healthcare needs were appropriately assessed and support plans were seen to be in line with these assessed needs. Each resident had access to appropriate health and social care professionals as required, and where eligible residents were engaged with national screening programmes. A clear and comprehensive summary form was in each resident's healthcare record outlining planned and completed appointments for an individual as well as reminders for staff to follow up on test results or reviews.

The registered provider and the person in charge had systems in place to keep residents safe. The team leader was on the day of inspection actively reviewing all safeguarding plans that were in place in the centre. The inspector reviewed a number that were ready for closing and some with actions still current and raised for review. Staff were knowledgeable in relation to keeping residents safe and how to report allegations of abuse if required. The inspector reviewed a number of intimate care plans and these were seen to guide staff. For residents who independently accessed their community, the team leader and person in charge had a clear protocol in place for staff to follow if the resident was delayed in returning home and for the resident in knowing what steps to take if for example they lost their mobile telephone or it was not charged.

Risk management systems were effective, centre specific and measured. There was a detailed and current risk register which included clinical and environmental risks and pertinent plans and environmental adaptations made to meet the changing needs. However the inspector noted that a small number of risks present in the centre were not included such as lone working. Any changes in residents assessed needs were promptly responded to. For example, a new risk assessment for one resident who had fallen twice in the community had been devised within a few days.

The use of the environmental restriction of window restrictors was implemented to ensure the safety of residents. In one house there was a locked fridge and cupboard and this was discussed on a regular basis by the registered provider via their human rights committee and reviewed by the psychology service. The inspector noted it was due for review by committee within one month of inspection. In one house sharp utensils were kept locked in the staff office and this practice had not been reviewed despite the team leader and staff acknowledging that the concerns that had initiated this practice were no longer present. A restrictive practice log was maintained by the team leader however this required review to ensure that all restrictions utilised were done so for the shortest time and in the least restrictive manner.

Some improvements were required in overall fire safety systems. All of the required fire safety management equipment was available and serviced regularly and in house checks were undertaken to ensure the systems were working. Residents had appropriate personal evacuation plans as required. While staff undertook regular drills with residents who were able to tell the inspector how these worked, the drill records in one of the houses in particular did not outline clearly outcomes or actions from the drill. Additionally in one house drills were only occurring via one exit point and on trialling a rear exit door the inspector noted there was no safe route out of an enclosed garden identified. In one house while there were fire doors in place upstairs, doors were observed to be held open and the door providing containment between one side of the house and another was not closed and had no mechanism to close in an emergency. In another house the fire doors on resident bedrooms had significant gaps along the bottom of the door and would not be effective in containing the spread of fire.

There were policies and procedures in relation to medicines management and suitable practices in relation to ordering, receipt, storage, and disposal of medicines. Audits were completed regularly and these were cross referenced with an external audit completed by a pharmacist to ensure continued best practice.

Regulation 17: Premises

Overall the inspector found that there was adequate private and communal space for residents and the provision of additional communal space was currently being explored by the provider. However there were a number of areas in need of minor repair and consideration with respect to adequate bathing facilities was required as outlined in the report.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

A number of identified risks such as lone working had not been addressed within the environmental risk register.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Fire containment arrangements in place did not protect the assigned evacuation route.

Improvements were required in the area of fire evacuation procedures and documentation of checks to ensure a safe and effective procedure was in place for evacuation.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Appropriate storage facilities were provided to store medicines in a secure manner. A sample of administration and prescription records were reviewed which were found to be clear and eligible while also containing all of the required information. Audits of medicines management were carried out and staff were provided with relevant training.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Personal plans were found to be person-centred and there was an assessment of need in place for residents which were reviewed in line with residents' changing needs. Support plans and risk assessments were developed in line with residents' assessed needs. However, improvement was required to documenting residents' social goals, to ensuring information was consistent across all documentation in residents' personal plans and in reviewing support plans to ensure they were effective.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had appropriate assessments completed and were given appropriate support to enjoy best possible health. Residents' changing needs were recognised and appropriate assessments and supports put in place. Residents had access to relevant healthcare and social professionals in line with their assessed needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

The use of restrictive practice was in place to promote the safety of residents but improvement's were required in relation to review of these practices to ensure guidance was clear for staff. This was also required to ensure that these practices were utilised for the shortest duration.

Judgment: Substantially compliant

Regulation 8: Protection

Systems for the protection of residents were proactive and responsive and also supported residents to develop the skills to protect themselves.

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	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Ardnore OSV-0003412

Inspection ID: MON-0023363

Date of inspection: 18/04/2019

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Staffing: There is an ongoing recruitment process within the organisation and three new staff members have been recruited for the Ardnore programme since the inspection. All are in the process of completing their full induction training and all have started shadow shifts in the locations. This will address the issue of inadequate staffing levels to support the resident's individual plans and will also provide extra support to address the changing needs of the residents in particular in Ardnore and Melville. The team leader is currently addressing the morning staffing hours in Ardnore to reflect the extra support required to ensure the safety of all residents during this busy time in the house. A second staff member will be working from 8am until 11.30am (changed from the previous 9.30am until 12.30pm) and will provide specific support in the areas of medication, dysphasia support and personal care.	
Regulation 24: Admissions and contract for the provision of services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services: All contracts of service have been reviewed and updated between 16.05.2019 and 03.06.2019 to reflect changes in individual circumstances of the resident, contribution/fee changes.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: On the 7.05.2019 the building and maintenance manager visited Ardnore to assess the requirements to address the lack of a shower in one of the upstairs bathrooms. Options included installing a walk in bath/shower to address any falls risks and quotations are	

currently being processed.

Some of the minor cosmetic works and repairs in Ardnore, Melville and Deansground have been addressed and completed and the remainder are currently on the maintenance list for completion by 30.07.2019.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
A lone worker risk assessment has been completed for each location and is now listed on the environmental risk register for each location in the designated centre.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
On Friday 19.04.2019 the health and safety officer from SOS visited Ardnore, Deansground and Melville Heights to assess work to be completed to address compliance issue.

Melville Heights :
The containment door upstairs in Melville Heights has been fitted with a closing mechanism and an up to date CEEP has been completed and signed off.
The glass at the top of the bedroom fire doors have been assessed and confirmed as fire resistant glass. The utility room door downstairs now closes correctly to ensure containment. Completed the 23/05/19.

Ardnore :
Following a number of visits to the house by the health and safety officer , housing and building manager and contracted builder the following has been agreed :

To address the high step leading from the utility room to the back garden this step will be removed. A suitable ramp will be installed to ensure safe access for all residents from the house to the back garden and also during an emergency evacuation or fire drill.

The current door in the garage (attached to the house) will be relocated to reflect ramp construction, usage and access issues. This door will be kept open at all times to address the safe emergency route out of the enclosed garden in the event of an evacuation or fire drill.

Appropriate lighting, hand rails and risk management will be addressed also as part of these building works.
CEEP and PEEP'S will be updated appropriately to ensure the specific needs of each resident is accounted for in the process.

Fire drills are now planned to take place upon completion of building works in Ardnore using the new route out to the back garden and all detail will be recorded.

To be completed the 30/07/19

Deansground:
All doors have been assessed and the gap is currently being addressed in conjunction with the builder and the health and safety officer. Completion date will be 30.06.2019. A closing mechanism will be fitted to the utility room door by this date also.

Fire Drills: All staff across the programme were informed of the requirement for more information during fire drills, in particular specific outcomes and actions for all / each resident including who was on the premises at the time and what were the scenarios taking place e,g: fire in kitchen etc..

The issue of time has been addressed also as it was noted that some drills were very fast and no detail provided to give context. Fire drills have taken place in Melville Heights, 28/05/19, Ardnore 10/06/19 and Deansground 29/05/19

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:
Staff meeting on 23RD, 24th and 30th May addressed concerns regarding specific goals for residents listed on their person centered plan. Specific recording of goals will be included in all house meetings for the next 6 months and will be specifically listed on all Quality Conversation meetings in the future.
The team leader introduced the new Keyworker workbook, which has been recently piloted and will be rolled out to the whole organization in the coming months. The new workbook will be used in the Ardnore programme to improve the required recording of the resident's goals to ensure information is consistent across all documentation. Training will be provided to staff in the July meeting with all staff in the programme.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The Behavioural therapist assessed and reviewed the risks and implications involved for one resident in Deansground on the 16/05/19. The outcome of this review was positive, as a result with guidance from behavioural support sharps / knives (unrestricted) were introduced back into the Deansground. This is to be reviewed monthly for the next 6 months to ensure risk and the use of restrictive practices is minimalised. Next review date is the 10/06/19 with multidisciplinary team .

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	31/07/2019
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	31/07/2019
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/07/2019
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 services to be provided for that resident and, where appropriate, the fees to be charged.	Substantially Compliant	Yellow	30/06/2019
Regulation 24(4)(b)	The agreement referred to in paragraph (3) shall provide for, and be consistent with, the resident's needs as assessed in accordance with Regulation 5(1) and the	Substantially Compliant	Yellow	30/06/2019

	statement of purpose.			
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	15/06/2019
Regulation 26(1)(b)	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 risks identified.	Substantially Compliant	Yellow	15/06/2019
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	30/06/2019
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/07/2019
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/06/2019
Regulation 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.	Substantially Compliant	Yellow	31/07/2019
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there	Substantially Compliant	Yellow	31/07/2019

	is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.			
Regulation 05(7)(a)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include any proposed changes to the personal plan.	Substantially Compliant	Yellow	31/07/2019
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	10/06/2019