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:	Galway Cheshire House
Name of provider:	The Cheshire Foundation in Ireland
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	16 and 17 April 2019
Centre ID:	OSV-0003445
Fieldwork ID:	MON-0023364

About the designated centre

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

The centre was a purpose built premises which provided a residential service for residents which physical and sensory disabilities. Each resident had their own apartment which contained an open plan kitchen, living and bedroom area. Each apartment also had a separate en-suite bathroom. Some residents had additional mobility needs and additional equipment such as hoists had been installed to support these residents with their mobility requirements. The centre was also able to support residents with some medical needs and some residents also attended the services of mental health professionals.

The provider employed a number of staff members directly and up-to-three staff members supported residents during day-time hours. On the day of inspection there was a sleep-in arrangement and one waking staff to support residents during night-time hours. There was also an allocation of nursing hours and social support hours to assist residents. Some residents also sourced personal assistants through an external agency and these assistants attended the residents as they required.

The following information outlines some additional data on this centre.

Current registration end date:	21/01/2021
Number of residents on the date of inspection:	9

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
16 April 2019	09:00hrs to 17:30hrs	Ivan Cormican	Lead
17 April 2019	09:00hrs to 14:30hrs	Ivan Cormican	Lead
16 April 2019	09:00hrs to 17:30hrs	Nan Savage	Support
17 April 2019	09:00hrs to 14:30hrs	Nan Savage	Support

Views of people who use the service

Inspectors met four residents who were able to openly voice their thoughts and feelings in regards to the service they received in the designated centre. All residents voiced their satisfaction with the service and spoke highly of the staff team and person in charge. A resident stated that they were openly supported to complain if they had any concerns and that staff actively listen and respond to their concerns. Residents stated that they felt comfortable to raise any issues in regards to care practices and a concern which was relayed to a staff team member and an inspector was reviewed prior to the conclusion of the inspection.

Capacity and capability

Overall, inspectors found there were some aspects of care provided which was maintained to a good standard; however, some aspects of service provision required improvements to ensure that the safety and quality of care was maintained to a good standard at all times.

Inspectors found that the person in charge had a good rapport with residents who spoke highly of their oversight and person centred approach to care. The provider had systems for the ongoing monitoring of care practices with external 'partners' visiting the centre on a regular basis to provide additional oversight. The person in charge was also conducting regular internal audits to ensure that the quality of care was promoted. However, inspectors found that significant improvements were required to these oversight arrangements as issues were found on this inspection in regards to a specific healthcare, risk management and personal planning. The provider had also conducted all audits and reviews as required by the regulations which found some issues which required improvements; however, no definitive timelines for completion had been assigned to these issues to ensure that they would be addressed in a prompt manner. Inspectors found that although there were oversight arrangements in place, these systems failed to identify real issues which were impacting on the quality and safety of care for residents. Improvements in these systems would further enhance the overall care provided and assist in building on many positive care practices which were found.

Staff who met with inspectors had a good knowledge of residents' care needs and residents stated that staff were very nice. The provider had systems in place to ensure that residents were supported by appropriately trained staff. The provider had also promoted the safety of residents by ensuring that all staff members had received safeguarding training; however, improvements were required in regards to overall training as all staff were not up-to-date with supporting residents with

behaviours of concern and a staff member with specific cleaning duties had not completed infection control training. Furthermore the person in charge was unable to clearly demonstrate that all staff members had received training in supporting residents with catheter care. Overall, inspectors found that some improvements in the oversight of staffing arrangements would further assist in the delivery of care which was tailored to meet resident's individual needs.

The provider had systems in place to ensure that resident could complain if they so wished and there was a complaints procedure prominently displayed. Residents were supported to understand the procedure through the residents' meeting forum and tailored one-to-one communications. A resident that spoke with an inspector also described how they felt comfortable in raising any issue to the person in charge and other staff. A sample of complaints were reviewed and found to have been investigated promptly. However, the satisfaction of the complainant with the outcome of the complaint was not consistently recorded to ensure that residents were happy with the outcome of their complaint.

Regulation 15: Staffing

A review of the rota indicated that residents received continuity of care from staff members who were familiar to them; however, some improvements were required to ensure that an accurate rota was maintained at all times. Some residents employed their own personal assistants personal assistants. These personal assistants attended the centre in-line with the resident's individual preferences and assisted with some personal care needs and social activities. The provider had a memorandum of understanding in place with an external agency that had oversight of these assistants, which stated that all required training and vetting disclosures were in place.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff who met with inspectors had a good knowledge of residents' care needs; however, some improvements were required to ensure that staff were up-to-date with their training needs.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had completed all required audits and reviews of care practices and there was regular ongoing auditing completed by external 'partners' which provided additional oversight. Although these systems had assisted in improving some care practices, these oversight arrangements failed to ensure that the quality of care was maintained a good standard at all times.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had produced a statement of purpose that was made available to residents and their representatives. This document contained the majority of requirements as detailed in Schedule 1, but aspects required review to ensure it accurately reflected the services and facilities provided. For example, it referenced that a resident's plan would be updated no less frequently than at three monthly intervals, but in practice this was not happening. While there was a description of rooms in the designated centre, the size of the en-suite bathrooms were not included. Inspectors also noted that the organisational structure had not been updated to reflect changes to the governance arrangements.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The provider had systems in place to ensure that residents' complaints would be recorded and responded to. Residents stated that they felt supported to complain and individual communication sessions were implemented for some residents to ensure that their opinions were heard. However, some improvements were required to documentation which was not consistently completed in regards to residents' satisfaction with the outcome of their complaint.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The complaints policy was reviewed under this regulation and found to require some improvement. The policy did not clearly describe how complaints were handled and investigated in this centre. For example, the complaints policy did not include the

appeals process and did not clearly describe how complaints were investigated. The person in charge informed inspectors that they had identified the need to amend this policy and that a review was currently underway.

Judgment: Substantially compliant

Quality and safety

There were risk management systems in place to support the safety of care which was provided to residents. Inspectors found several good examples where issues such as an increase in falls had been identified and additional risk management and care planning had been implemented to good effect. However, improvements were required in regards to the overall identification and management of risks. The provider's risk management policy stated that a risk register should be maintained, but risks which impacted on residents were not contained on the available register. Furthermore, the provider's risk management policy indicated that risks which could not be managed in the centre were required to be escalated to the provider; however, there was no indication as to what constituted a risk which could not be managed. For example, a risk which present on the day of inspection was rated at extreme risk, but had not been escalated to the risk register or the provider. Although this risk had been referred to a 'quality partner' the overall provider had not been made aware. Inspectors found that the lack of a clear escalation pathway resulted in a disjointed approach to risk management which could impact on the overall quality and safety of care which was provided to residents. Overall, inspectors found that although there were examples where risk management procedures had improved the safety of care, improvements were required to both procedures and practice to ensure that the safety of care which was provider to residents was maintained to a good standard at all times.

Residents who met with inspectors voiced their satisfaction with the service and some residents stated that their opinions were actively sought in regards to how the service was run. All interactions between staff and residents were observed to be warm in nature and staff members who met with inspectors had a good understanding of resident's individual care needs. There were no active safeguarding concerns and all staff had received training the protection of vulnerable adults. Not all staff had also received training in supporting residents who may engage in behaviours of concern, but there were no behavioural support plans in the centre and inspectors found that this had little impact on the quality of care which was delivered.

Residents had good access to allied health professionals and there were comprehensive 'best possible health' plans completed for all residents. Comprehensive care plans had been developed in response to many health

care issues which had been identified and staff who met with inspectors had a good knowledge of residents' care needs. Inspectors found that these arrangements promoted consistency in care practices which was delivered to residents. A detailed plan of care had also been implemented in response to a risk to a resident's skin integrity and ongoing monitoring and review had been implemented by the staff team. However, there were inconsistencies in care planning which did not fully account for the night-time care arrangements and inspectors found that this could significantly impact on the quality of care provided. This was brought to the attention of the provider on the morning of inspection and an interim care plan was implemented which demonstrated that the care needs of the residents could be met. The provider also indicated that this care plan would be subject to review within 72 hours of the inspection and further referrals had been made to the resident's general practitioner and multidisciplinary support.

The provider had taken fire precautions seriously and fire safety systems such as fire doors, emergency lighting, fire alarm and fire fighting equipment was installed. Staff were completing regular checks of these systems and competent people were scheduled to service fire safety equipment as required. There were also regular fire drills occurring; however, some improvements were required as records were not available for review to demonstrate that all residents could be evacuated when minimal staffing was available. Further improvements were also required to documents which aided in the evacuation of residents as some of these had not been regularly updated.

Each resident had a personal plan in place and residents were supported to identify and achieve personal goals including attending music groups, public speaking and sporting events. Inspectors found that these goals were reflective of resident's personal interest and residents who met with inspectors were happy to discuss these interests in further detail. Inspectors found that these arrangements ensured that resident's social and personal interests were actively promoted and kept to the forefront of care. However, some improvements were required in regards to the assessment and ongoing review of some personal plans which were reviewed. For example, an inspector found that some sections of a resident’s assessments and personal plan were not completely accurately and a comprehensive assessment for another resident had not updated in-line with a change in their care support needs. An inspector also noted that this resident had been discharged from the designated centre during 2017 and re-admitted several months later. However, the resident’s personal plan had not been reviewed following re-admission. There was also evidence that residents were actively consulted in regards to reviews of their personal plans; however, some additional improvements were required to ensure that multidisciplinary supports were involved as required. Overall, inspectors found that some aspects of personal planning were of a good standard and supported the social inclusion of residents in their local communities; however, significant improvements were required in regards to the overall assessment and on-going review of personal planning for some residents.

Regulation 13: General welfare and development

Residents had good access to their local community and they had been consulted with about their preferences for further education, training and employment. Some of the residents that communicated with inspectors described the different educational and volunteering opportunities they were currently pursuing.

Suitable support was provided to residents to ensure that they could achieve their individual choices and interests, as well as their assessed needs as detailed in their personalised future plans. Residents actively participated in and enjoyed a variety of social and developmental activities in the centre, at day services and within the wider community.

Judgment: Compliant

Regulation 26: Risk management procedures

There were oversight arrangements in place for the management of risks and there was evidence that some risks were effectively managed. However, some improvements were required in regards to the overall management of risks to ensure that a risk register was maintained and that a clear escalation pathway was in place to facilitate the person in charge to raise concerns with the provider.

Judgment: Not compliant

Regulation 28: Fire precautions

Fire safety was taken seriously by the provider and fire equipment, procedures and systems had been implemented to ensure that the safety of residents was promoted. Fire drills were also occurring at regular intervals which indicated that residents could be evacuated on a phased basis and further review with an external partner had been implemented following incomplete evacuations. However, some improvements were required as fire drill records were not available for review to indicate that all residents could be evacuated from the centre when minimum staffing was available. Some documentation also required review as it had not been recently updated.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

There were appropriate storage facilities for medicinal products and staff who met with inspectors had detailed knowledge of the safe administration of medications. Resident's had also been supported to manage their own medications and the person in charge was actively monitoring the occurrence and frequency of medication errors to ensure that these did not impact on the safety of care which was in place for residents. Inspectors found that these arrangements ensured that both the safety and quality of care were maintained to a good standard at all times.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident had a personal plan in place which supported the personal and social interests of residents. However, some improvements were requires in regards to the overall assessment and review of personal planning to ensure that it was subject to multidisciplinary review, accurate and up-to-date. Further improvements were also required to ensure that personal plans were in an accessible format all residents.

Judgment: Not compliant

Regulation 6: Health care

Residents had good access the medical professionals and staff who met with inspectors had a good knowledge of resident's individual care needs. Some improvements were required in regards to supporting a resident with their skin integrity. This was brought to the attention of the provider on the day of inspection and an interim plan was implemented to meet their care needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were some restrictive practices in place on the day of inspection, but the provider had systems in place to ensure that these were reviewed on a regular basis and that the least restrictive practice was implemented. There were no behavioural support plans in place on the day of inspection.

Judgment: Compliant

Regulation 8: Protection

There were no active safeguarding plans in place on the day of inspection. Residents who met with the inspector generally voiced their satisfaction with the service. A resident was unhappy with one aspect of their service and this was brought to the attention of the person in charge and the relevant notification was submitted subsequent to the inspection.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights were promoted and the designated centre was operated in a way that respected resident's individuality. Arrangements were in place for residents to access advocacy services and there was evidence that they were consulted and participated in how the centre was organised. Appropriate arrangements had been implemented to ensure resident's privacy and dignity was respected.

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	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Galway Cheshire House OSV-0003445

Inspection ID: MON-0023364

Date of inspection: 16/04/2019 & 17/04/2019

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: - The centre rota has been amended to ensure that staff on leave are recorded as same. - The centre rota has been amended to display only staff working in the designated centre.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: - Infection control training has been arranged for staff members who require on 27th May 2019 - Catheter care training has been arranged for all staff members who require on 5th June 2019. - Positive Behavioural support training is scheduled for all staff who require it on 28th May and 14th June 2019. - Compliance in training will be reviewed quarterly by the PIC/PPIM through the Provider's Training Matrix and training courses will be scheduled as required. Next review 24th June 2019	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
- All reports from 6 monthly unannounced internal audit visit will detail any follow up actions required by the centre or Provider.
- Following receipt of the report from each unannounced internal audit visit, the PIC will meet the Centre's local management team to assign actions to responsible persons with completion by dates.
- The Regional Manager will meet with the PIC within ten working days following the unannounced visit to monitor progress on actions and agree any further supports required.
- The Provider's External Regional Partners will provide support and practical advice during monthly site visits to the centre, to ensure follow up actions are completed as required by the internal audit report.
- Should any difficulty with completion of actions occur this will be escalated to the Regional Manager and to the Provider representative to establish reasons and what is required to ensure completion.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
- The Statement of Purpose has been amended on May 21st 2019 to ensure it accurately reflects the services, centre layout and staffing arrangements for the centre.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
- The PIC will ensure that a satisfaction survey is completed for each complaint and residents are offered the opportunity to state if they are happy with the outcome.
- If a complainant is dissatisfied with the outcome of a complaint a local operating procedure is in place for people to appeal to named Provider staff member working externally to the centre.
- The provider is updating the complaints policy to ensure that the procedure for dealing with complaints, including how to appeal if dissatisfied with an outcome, is clearly stated

in the policy.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: - The provider is updating the complaints policy to ensure that the procedure for dealing with complaints, including how to appeal if dissatisfied with an outcome, is clearly stated in the policy.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: - The Provider will update The Risk Management Policy to ensure it provides clear direction for the Centre staff and management in Galway Services and nationally on criteria and pathway for escalation of major risks(rating above 15) to the Provider's Senior Management Team and National Risk Committee. The Policy will be reviewed and approved by 30th June 2019 - Until 30th June all risks falling into the major category will continue to be escalated by the PIC and Regional Manager to The National Health and Safety Risk Manager and Head of Clinical Services for review. - The Provider is reviewing arrangements for the governance and over sight of risk on a national basis. The Provider is updating the current Risk Management Policy which will outline how and when risks are escalated to the Provider's Risk Management Committee. This new system will hold risks rated 15 above and allow Cheshire to track all major risks more clearly and effectively whilst supporting services to implement necessary controls. - Risks which impact on residents will be listed in the centre's Risk Register as well as in Personal files

Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: - A Fire drill was conducted on 21st May 2019 with minimum staffing levels in place to ensure that all residents can be evacuated from the centre. - All fire drill records are available in the centre. - All fire drills will contain action plan detailing follow up actions required , dates and persons responsible	
Regulation 5: Individual assessment and personal plan	Not Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: - All care plans for residents in the center have been reviewed by the PIC and are in date. - Care needs assessments have been updated for all residents who require it. - Care plan reviews will be scheduled for all residents at least annually by the PIC and management team. Care plan reviews will involve Multi-disciplinary input appropriate to the resident. - The Provider's Regional Quality Partner and Regional Clinical Partner will monitor the completion of individual assessments during monthly site visits and support the PIC and management team to follow up on any required updates. - Care plans of any resident who leaves the center for an extended period will be reviewed on their return to the center. - Accessible care plans will be developed for each resident who wishes to have one.	

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(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	21/05/2019
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	14/06/2019
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	Not Compliant	Orange	27/05/2019

	safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the 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.	Substantially Compliant	Yellow	27/05/2019
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	30/06/2019
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where	Substantially Compliant	Yellow	21/05/2019

	necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.			
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	02/05/2019
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	21/05/2019
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Substantially Compliant	Yellow	30/06/2019
Regulation 04(1)	The registered provider shall prepare in writing and adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	30/06/2019
Regulation 05(1)(a)	The person in charge shall	Substantially Compliant	Yellow	20/05/2019

	ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	20/05/2019
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Substantially Compliant	Yellow	31/07/2019
Regulation 05(6)(a)	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	Substantially Compliant	Yellow	20/05/2019

	needs or circumstances, which review shall be multidisciplinary.			