Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Azalea Services
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Roscommon
Type of inspection:	Unannounced
Date of inspection:	16 December 2019 and 17 December 2019
Centre ID:	OSV-0004463
Fieldwork ID:	MON-0026159

About the designated centre

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

Azalea Services is a residential service, which is run by the Brothers of Charity Services. The centre provides accommodation and support for five male and female adults over the age of 18 years, with moderate to severe intellectual disability, including those with challenging behaviour and autistic needs. The centre comprises of two bungalows which can accommodate two and three residents in each and have suitable facilities and accommodation. Both bungalows comprise of single residents' bedrooms, en-suites, shared bathrooms, office spaces, kitchen and dining areas, utility areas and sitting rooms. Residents also have access to garden areas.Both houses are located in close proximity to each other on the outskirts of a large town. Staffing is available all times to support the residents and residents attend day services locally during the week. There are two staff in one house and a single staff in the second. Both waking and sleep over staff are provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 16 December 2019	16:00hrs to 19:30hrs	Noelene Dowling	Lead
Tuesday 17 December 2019	08:00hrs to 12:30hrs	Noelene Dowling	Lead

What residents told us and what inspectors observed

The inspector met with three of the four residents in both houses. The residents were unable to communicate verbally with the inspector and found it difficult to have a strange person in their home and this was respected. However, the inspector was permitted to observe some of their activities and routines. They were working with staff to put up the Christmas tree in one house and were involved in doing table top games and activities.

The residents appeared to be comfortable in their home, and their primary care needs were being well supported. The staff responded quickly to their non verbal communication and behaviours and assisted them gently with their meals and other tasks.

Capacity and capability

This monitoring inspection was carried out in order to ascertain the providers continued compliance with the regulations. The centre was last inspected in June 2018 with a high level of compliance found. The provider had not completed the required fire safety works to the premises within the agreed timescale as set out in the conditions of registration. As a result the provider submitted an application to vary/extend the time scale of the condition attached to the registration of the centre. This was granted by the Chief Inspector on 10 December 2019.

This inspection however, found that the governance arrangements and systems in the centre had deteriorated and were not sufficient to provide effective oversight and direction of practices in this centre. The person in charge had been appointed in March 2019 and had the required qualifications, experience and knowledge to carry out the role. However, the person was also responsible for another designated centre and day service provision. This significantly impacted on the capacity to provide oversight to this centre despite the evident best efforts of the post holder. Both centres, under the remit of the person in charge, supported residents with high support needs. The ability to be present in the centre and familiar with the specific or changing needs of the residents was impacted on by this arrangement, despite the best efforts of the person in charge.This was evident during the inspection.

The inspector was advised that a considerable amount of the person in charges time was taken up with operational tasks such as rostering. The inspector was advised that this arrangement was to be supported by the allocation of six hours protected time to another staff member for the purpose of delegating some tasks but this had not materialised. The provider advised that funding is a significant issue in managing the service. The findings of this inspection in relation to residents support plans and

adequate reviews of care, risk management, supervision of staff, staff training were impacted by the current management arrangements.

The arrangements for the management of staff required review. There was sufficient staff with the skill mix and competencies to provide the care the residents required, with one to one staff in one house and two staff at all times, including overnight, in the second house. While a number of internal locum staff were used, they were familiar with the residents and this supported consistency of care. However, deployment arrangements for staff required review. The provider advised that this was a nurse led service which indicates that the residents required a level of nursing oversight.The findings of this inspection demonstrate this in terms of follow up on clinical care needs. However, in practise, the inspector saw that the availability of nursing support was limited to one person, whose schedule included night duties.This limited the capacity to provide clinical support or direction of residents care. In addition, there was no specific function or area of responsibility outlined for this role.

According to the training documents available to the inspector, there was a regular schedule of mandatory training provided. However, there were significant gaps in both refresher and initial training in matters such as behaviour supports, medicines management, and safeguarding of vulnerable adults. The records noted a "no show" in a number of areas for staff, but there was no evidence that where this was a consistent lack of attendance as it was being addressed by management.

The records available to the inspector indicated that no formal supervision had taken place since 2017. Formal staff supervision is a requirement of the regulations aimed at ensuring staff practices are continually meeting the residents' needs. The records of those meetings which had taken place indicated the content was not focused on residents' care and staff development to provide this. Given the lack of availability of the person in charge to provide on the ground supervision this is of concern for the residents' welfare. Practices in regard to safe recruitment of staff was not reviewed on this inspection as the files are stored in a separate location.

These combined factors do not support consistent care for the residents and influence the findings in the quality and safety section of this report and could, if not addressed, present a risk to the residents' wellbeing.

There were a number of quality improvement systems implemented but these were limited to a health and safety audit of the premises and medicines administration audit. The provider undertook unannounced visits and these had identified a number of issues, including systems for risk management and reviews of the residents' personal plans. These audits had not been effectively actioned however. None the less, a further unannounced and comprehensive visit had taken place by a senior manager in the organisation just prior to this inspection, but the inspector was advised that this report was not yet available. The annual report for 2018 was completed. This acknowledged challenges for the centre, such as the need to complete the fireworks, which were being undertaken.

However, overall, the inspector found that systems relied on or implemented for the

evaluation of practices and recording of incidents in the centre did not support the provider's capacity to be assured of the quality and safety of care.

This was demonstrated in the system for recording and responding to incidents in the centre. There were obvious discrepancies found in relation to incident reporting, data analysis or specific areas of responsibility for reviews and implementing any changes needed. For example, the inspector reviewed data in relation to incidents in one of the houses in 2019. However, this information did not correlate with the formal incident records for the centre, either in hard copy, or on the new computerised reporting system which is where this information should have been recorded in accordance with the provider's processes. In addition, from a number of incidents reports which were available, there was no evidence that a sufficient review of the incidents had taken place in the immediate aftermath. Therefore it was not evident that the provider was using information sufficiently to identify issues and implement changes if needed.

The inspector reviewed the statement of purpose which had recently been revised. This document required a number of amendments to accurately describe the service to be provided, on what basis, and to whom.

Regulation 14: Persons in charge

The person in charge had been appointed in March 2019 and had the required qualifications, experience and knowledge to carry out the role; However, the provider had not made suitable arrangements to facilitate the person in charge to carry out the role effectively while being in charge of more than one centre.

Judgment: Not compliant

Regulation 15: Staffing

While the numbers of staff available was satisfactory the deployment and availability of nursing oversight required review to ensure the skill mix was appropriate to residents' needs.

Judgment: Not compliant

Regulation 16: Training and staff development

There was a regular schedule of mandatory training provided. However, there were significant gaps in both refresher and initial training in matters such as behaviour supports, medicines management, and safeguarding of vulnerable adults with no evidence that actions were taken to ensure staff attended this training.

There were no effective staff supervision systems implemented.

Judgment: Not compliant

Regulation 21: Records

The records pertaining to the residents assessments of need and care and support while cumbersome, were not comprehensive, or maintained in a manner so as to ensure completeness and access.

Judgment: Substantially compliant

Regulation 23: Governance and management

Arrangements for management and oversight of the centre required review to provide suitable and sufficient care and oversight of practice.

The systems for monitoring of practice and ensuring the safety and welfare of the residents were not robust and currently effective

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose required a number of amendments to accurately describe the service to be provided, on what basis, and to whom.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

From the records which were available to the inspector the person in charge was submitting the required notifications to the Chief Inspector.

Judgment: Compliant

Quality and safety

It was apparent that the provider was committed to the welfare of the residents. This is supported by the low numbers of residents living in each house and the fact that compatibility and individual needs were considered in these living arrangements. Staffing levels supported the individual and complex needs of residents for engagement, activities and care. The residents had access to the community and attended day services tailored to their individual needs, preferences and levels of ability. Within the centre, they had their preferred activities, including table top games, hand massage and enjoyed a "lie in" and social activities at the weekends. Additional transport had been purchased to ensure the residents who required accessible transport, could attend their chosen activities and day services.

Their primary care needs were being very well supported and staff were observed to be attentive and engaged with the residents. The provider outlined plans to renovate the centre and to provide a larger and more suitable bathroom for a resident whose changing needs required this. This was planned to take place in early 2020 and will require the residents being relocated for a period during this time. These arrangements were in place. Both houses were very homely and comfortable.

Nonetheless, there were a number of areas for improvement identified in order to ensure that the residents' current and changing care needs were being met within the centre. These can be seen to correlate directly to the oversight and supports currently in operation in the centre.

The residents had access to a range of multidisciplinary assessments including physiotherapy, speech and language, dietician, and neurology. However the systems for implementation of adequate support plans and annual reviews of the residents' care was not consistent across both houses. In one house, there was evidence of frequent multidisciplinary reviews and detailed support plans implemented for all identified needs including self harm, behaviour support and personal care and medical needs.

However, the residents in the second house did not have adequate or updated risk or support plans for identified needs, including manual handling, use of hoist, falls risks or epilepsy or other ongoing health care issues. No annual reviews, informed

by the multidisciplinary assessments of the residents needs had taken place, as required by the regulations, to ensure that their care and development was continually re-valuated. There were "personal outcome" plans available but no system for ensuring that the goals set for the residents, mainly social, had been achieved or were meaningful to the residents.

The systems for follow up on referrals and ensuring that basic information regarding the residents changing or chronic health care needs were understood, required review, so as to ensure that treatments recommended were implemented and followed up on. For example, in one instance, a clinician had recommended that a resident have a full dental review to ascertain if pain might be a factor in escalating behaviours. The provider could not demonstrate that this had been completed or had been organised. Another resident was being monitored, by day, for seizure activity. However, in this instance, staff were unable to provide the relevant information to the inspector regarding this issue. These findings indicated a lack of oversight and direction of the care provided.

The systems for safeguarding of residents were satisfactory and the inspector was informed that there were no current concerns of this nature. The provider had social work services to support good safeguarding practices. The residents required full support with personal care .The plans available did not provide any guidelines as to how to protect the residents' privacy, dignity and integrity in this matter. The inspector was advised that this was recognised and being included in training which was due to commence in the first quarter of 2020.There was an effective system for the management and oversight of the residents' finances.

However, the residents' privacy was compromised by the fact that their daily diaries and loose pages, which contained very personal and intimate care information, were left in full view for any visitors or contractors to see, on a table in the dining room. Privacy arrangements for residents' personal information required review.

There was good access to supports for the management of behaviours that challenge, with psychiatric and psychological intervention and detailed support plans were available. Staff were able to inform the inspector of these and how they assisted the residents at such times. However, the reviews of a number of incidents which had occurred did not demonstrate that the preventative strategies and triggers, which were clearly defined, were adhered to by staff. For example, an incident of self-harm outlined that a resident had been left unattended at a particular time. This was signed off by the person in charge but without effective review, as it was contra indicated by the behaviour plan.

A small number of restrictive practices were implemented in the centre. While these were assessed as necessary, the provider's policy requires that these be reviewed annually by the human rights committee. This is a way for the provider to ensure that the practices are safe, continue to be necessary and the only option available. However, the reviews and decisions of this committee could not be located by staff in relation to a number of the restrictions including the wearing of a particular garment. This does not provide assurance to the provider of the appropriateness of

these procedures.

There were improvements required in the management of risk for the residents. The risk register was a generic document and did not reflect the centre or the particular profile of residents who lived there. While some residents had very detailed individual management plans available, others did not and strategies had not been updated to reflect important changes, such as decreasing mobility for a resident.

Required improvements in relation to fire safety, including the completion of the installation of fire doors in one of the houses, were in the process of being addressed in accordance with provider's plans which had been submitted to the Chief Inspector. These works were expected to be completed by the 31 January 2020. The provider is expected to inform the Chief Inspector when these works have been addressed. The works required in one house had been completed. Records seen demonstrated that all of the fire safety management equipment including the fire alarm, emergency lighting and extinguishers were in place and serviced as required. Fire evacuation drills were undertaken with the residents.

Medicine management practices were reviewed and in the most part safe. Regular medicines audits took place and this helped to support good practice. However, the inspector found that the protocol for an emergency medicine differed in the dosage required from that detailed on the prescription.

Regulation 17: Premises

The premises were homely and well maintained. The provider had plans to renovate a bathroom to facilitate the changing needs of the residents.

Judgment: Compliant

Regulation 26: Risk management procedures

The risk register was a generic document and did not reflect the centre or the particular resident profile in this centre. While some residents had very detailed individual risk management plans available, others did not and strategies had not been updated to reflect changes such as, decreasing mobility for a resident.

Judgment: Not compliant

Regulation 28: Fire precautions

Non-compliances in relation to fire safety, including the completion of the installation of fire doors in one of the houses, were in the process of being addressed in accordance with plans previously submitted to the Chief Inspector. These works were expected to be complete by the 31 January 2020.

All of the fire safety management equipment including the fire alarm, emergency lighting and extinguishers were in place and serviced as required. Fire evacuation drills were undertaken with the residents.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Structures were in place to support safe medication practices for the most part. However, the inspector found that the protocol for an emergency medicine differed in the dosage required from that detailed on the prescription and this discrepancy was being addressed.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The residents had access to a range of multidisciplinary assessments including physiotherapy, speech and language, dietician, and neurology. However the systems for implementation of adequate support plans and annual reviews of the residents' care was not consistent with some residents not having such plans for assessed needs. No annual reviews, informed by the multidisciplinary assessments of the residents' needs had taken place, as required by the regulations, to ensure that their care and development was continually re-evaluated.

Judgment: Not compliant

Regulation 6: Health care

The systems for follow up on referrals and ensuring that basic information regarding the residents changing or chronic healthcare needs were understood, required review, so as to ensure that treatments recommended were implemented and

followed up on.

Judgment: Not compliant

Regulation 7: Positive behavioural support

There was good access to supports for the management of behaviours that challenge, with psychiatric and psychological intervention and detailed support plans available. However, the reviews of a number of incidents which had occurred did not demonstrate that the preventative strategies and triggers, which were clearly defined, were adhered to by staff and that this was addressed to ensure the residents were adequately supported.

Judgment: Substantially compliant

Regulation 8: Protection

The systems for safeguarding of residents were satisfactory and the inspector was informed that there were no current concerns of this nature. The provider has integral social work services to support this.The plans available in relation to the provision of intimate personal care to the residents did not provide any guidelines as to how to protect the residents' privacy, dignity and integrity in this matter. The inspector was advised that this was recognised and being included in training which was due to commence in January 2020.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The residents' privacy and dignity was compromised by the fact that their daily diaries and loose pages, which contained very personal and intimate care information, were left in full view for any visitors or contractors to see, on a table in the dining room

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Azalea Services OSV-0004463

Inspection ID: MON-0026159

Date of inspection: 16/12/2019 and 17/12/2019

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: A Team Leader post of supernumerary hours is now being recruited. This will support the PIC to carry out the role effectively and ensure oversight arrangements are in place.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Currently there is one person who requires high medical supports. There is a skill mix of nursing, social care and support workers on the roster. The nursing hours are rostered for day, evening and night duty, and this supports the needs of all people supported. The nurse had been on leave for the previous three months and there was no success in recruiting a replacement nurse. The nurse has now recommenced duty and is supporting all people with their clinical and medical needs.	
Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
All Staff training records have been reviewed and all staff have been scheduled for outstanding training.
There is a suite of mandatory trainings available and scheduled for all staff.
Attendance at training is on team meeting agenda and will continue to be highlighted to staff.

Staff, support and supervision meetings are being scheduled with all staff. The recruitment of the team leader will support the PIC in ensuring Staff are provided with supervision.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
All records are being reviewed and updated. Updated Personal folders are being complied for each person supported with updated records.
Record-Keeping training for all staff has been arranged on site.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A team leader of supernumerary hours is now being recruited.
This will support the PIC to ensure there is robust and effective arrangements for monitoring of practice and ensuring the safety and welfare of the people supported.

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 updated and includes a description of the service provided on what basis and to whom.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Risk Assessments are being reviewed and the risk register will be updated to reflect changes in needs of people supported.
The risk register is updated as changes occur to ensure that it is live document at all times.
The PIC has completed Risk Management training and all staff are scheduled to complete this training.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
This discrepancy in dosage required and detailed on the prescription has been rectified.

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:
Personal Plans are being updated for all people supported with review dates put in place.

There is regular MDT input for people supported as required. There will be further MDT assessments and reviews are planned. Going forward these reviews will also be included in the overall Annual Review for the designated centre.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Health Support Plans are being reviewed for all people supported with the support of nursing staff, to ensure that all information regarding people's healthcare needs is up to date and that treatment recommended are implemented and followed up on.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
A team meeting has been scheduled with the Behaviour Support Team to review the Behaviour Support Plan for person supported and ensure that all team members are aware of reactive strategies and triggers.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
All Intimate Care plans and protocols are being reviewed. Training for staff in Personal Development, Relationships and Staying Safe has been scheduled for the first Quarter of 2020.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The current renovations will ensure that all personal diaries are kept in the private office space at all times. Record keeping policy, confidentiality and safe storage are part of record-keeping training and staff will be trained in this at on-site training.

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 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Not Compliant	Orange	28/02/2020
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Not Compliant	Orange	03/01/2020
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including	Not Compliant	Orange	31/05/2020

	refresher training, as part of a continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/05/2020
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	31/03/2020
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	13/03/2020
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	13/03/2020
Regulation 26(2)	The registered	Not Compliant	Orange	31/03/2020

	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.			
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.	Substantially Compliant	Yellow	17/12/2019
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	24/01/2020
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal	Substantially Compliant	Yellow	31/03/2020

	plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).			
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 needs or circumstances, which review shall be multidisciplinary.	Not Compliant	Orange	31/03/2020
Regulation 06(2)(b)	The person in charge shall ensure that where medical treatment is recommended and agreed by the resident, such treatment is facilitated.	Not Compliant	Orange	31/03/2020
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	28/02/2020
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental	Substantially Compliant	Yellow	28/02/2020

	restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			
Regulation 08(6)	The person in charge shall have safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.	Substantially Compliant	Yellow	28/02/2020
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	20/03/2020