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:	No.5 Fuchsia Drive
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Announced
Date of inspection:	15 October 2019
Centre ID:	OSV-0004577
Fieldwork ID:	MON-0022573

About the designated centre

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

In this centre a full-time residential service is provided to a maximum of four residents; however, a shared care arrangement with home is also facilitated. All of the residents in the context of their disability require support from staff but the level of support provided is individualised and advised by an assessment of each resident's needs and preferences. For example some residents may require minimal staff support for some daily routines such as personal care but would have a requirement for more staff support in other areas such as monitoring of health and well-being. The provider aims to support residents to live ordinary lives as valued citizens in their community while remaining connected to family and friends. The provider strives to provide each resident with a safe home and quality support that meets their assessed needs and personal choices.

The centre is located in a mature residential setting on the outskirts of the busy local town; transport to the amenities offered by the town and the services utilised by the residents is available. The premises itself is a dormer type property with a garden to the rear.

The model of care is social and given the level of support needed from staff there are ordinarily two staff on duty when residents are present in the house with the exception of the night-time arrangement which is one staff on sleepover duty. The staff team is comprised of care assistants and social care workers; supervision and day-to-day general oversight is provided by the unit leader under the direction and supervision of the person in charge.

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
15 October 2019	09:00hrs to 16:30hrs	Mary Moore	Lead

What residents told us and what inspectors observed

The inspector met with two of the four residents, one briefly as residents' avail of day service programmes that are delivered off-site and in the house itself. On the day of inspection three residents were attending off-site day services. Residents welcomed the inspector to their home and invited the inspector to view their own personal spaces within the house.

Resident's views of the service were largely gathered by way of observation and review of records. The inspector saw that residents had good-control of their personal space and maintained this space in line with their choosing and requirements; for example locking their door when not present in the centre. The inspector noted that residents were aware of and adhered to their agreed supports such as transporting communication books and other items to the day service to ensure continuity of care and support or maintaining with staff a log of the day's dietary choices and activities. Residents knew the staff on duty and the staff due to come on duty; residents knew what their plans for the afternoon were. Residents presented as relaxed and comfortable in their environment and with staff. Staff were respectful in their communication with residents and when speaking of them; staff had ready knowledge of each resident's needs and wishes, their individuality and their plan of support.

Capacity and capability

Overall the inspector found that this was a well managed service the objective of which was to provide each resident with a safe, quality service that was appropriate to their needs. The service presented as adequately resourced to deliver on this objective. There were areas that needed to be addressed as they impacted on the delivery of an optimal service to each resident. The provider had however also identified these areas, recognised their impact and was in the process of addressing them; hence the inspection finding that overall and on balance the centre was effectively managed. Actions did however issue in these areas and these are described in the relevant section of this HIQA (Health Information and Quality Authority) report.

The management structure was as stipulated in the statement of purpose and function for the service (a record that the provider is required to maintain and that sets out information on management but also for example in relation to staffing, the facilities provided or how to make a complaint). While this particular management team was relatively recently established, persons participating in it were suitably experienced and understood their individual roles, responsibilities and reporting relationships. The inspector found that the team worked effectively together, for

example front-line staff said that they could speak openly and were listened to; the unit leader said that she had the access that she needed to the person in charge who in turn was supported by her manager; matters arising were escalated to the level where they could be addressed.

Staff described the types of reviews completed so as to establish and monitor the quality and safety of the support and services provided to residents, for example the regular and annual reviews of residents' plans of support, the review of incidents and accidents and the monitoring of the control of identified risks. In addition the inspector reviewed reports of the providers own service reviews as required by the regulations on an annual and six-monthly basis. Overall these reports indicated that the reviews were comprehensive and focussed on the appropriateness, quality and safety of the service and support provided to residents. The reviewer identified matters that had the potential to or were impacting on the quality and safety of the service; for example staffing or the suitability of the service to all residents needs. The implementation of the action plan was allocated to the appropriate persons; front-line staff were responsible for addressing issues such as the review of residents' records; staffing and premises matters were escalated to those with the necessary authority to address them. However while there was evidence of the providers intent to address these matters they were not fully or satisfactorily resolved at the time of this inspection.

For example it was evident to the inspector that the provider sought to ensure that staffing levels and arrangements were suited to and met residents' needs and requirements. Additional staff resources were provided each evening up to 10:00hrs and at weekends with three staff on duty on Sunday. Staff resources were utilised so as to provide the support necessary but also to optimise the individualised nature of the service; for example each resident had an evening set aside where they could enjoy an individualised event of their choosing rather that a collective outing with peers. Therefore while staffing levels and staff allocations were adequate, the issues arising were the recent turnover of staff, staff retention, a reliance on relief staff and the requirement for staff to have specific training to meet a specific healthcare need; the monitoring and administration of insulin considered to be high alert medicine (at high risk of causing significant patient harm if used in error). The provider did consider this training requirement and the need for consistency when planning the staff rota and a regular group of relief staff worked in the centre. There was a requirement however in the context of residents needs to regularise staffing as of the eight staff that worked in the centre (and as identified on the staff rota) only two staff including the unit leader were regular staff with the remaining shifts covered by six relief staff each week. This created challenges to planning and maintaining the staff rota, maximising consistency for residents, ensuring there was a staff available at all times with the necessary skills to meet resident needs as specified above and staff who were suitably and adequately inducted on residents' needs and local procedures such as the evacuation procedure.

Staff spoken with did have the knowledge, skills and attitude needed for them to perform their role and to provide residents with the care and support that they needed. Staff responded positively to the process of inspection and understood how review and inspection informed improvement. Staff confirmed their attendance at

mandatory, required and desired training such as responding to behaviour of risk, medicines management and first aid. Training records indicated that staff were facilitated to attend training and that attendance was monitored. In addition the inspector reviewed a random sample of staff files. These files were complete and contained all of the required records including evidence of qualifications suited to their role and work.

The provider had complaints management procedures and staff supported residents to access and use them; representatives were also, based on records seen, aware of their right to complain and how to complain. The two most recent complaints were received in mid 2018 and early 2019. The issues causing dissatisfaction were clearly recorded as were the actions to be taken; the matters complained of reflected these inspection findings and the providers own improvement plan; it was evident that the provider was seeking to resolve these matters, for example in seeking consistent staffing and making environmental modifications. However, specifically in relation to complaints management procedures what was not recorded was whether the complainant was satisfied or not with how their complaint was responded to and addressed.

Registration Regulation 5: Application for registration or renewal of registration

Prior to this inspection a complete and valid application for the renewal of registration of the centre was submitted within the specified timeframe by the provider to the (HIQA).

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge worked full-time and had the qualifications, skills and experience necessary to manage the designated centre. The person in charge was aware of their role and responsibilities under the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. The person in charge had the practical support needed to effectively manage the centre from the unit leader. Staff described the person in charge as accessible and approachable.

Judgment: Compliant

Regulation 15: Staffing

In the context of residents' needs and to optimise consistency for them there was a requirement to regularise staffing. Of the eight staff that worked in the centre only two staff including the unit leader were regular staff with the remaining shifts covered by six relief staff each week.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff were provided with the training required to provide a safe and effective service to residents. Staff had training in safeguarding of adults, safe administration of medication, behavioural support and fire safety. Attendance at refresher training was monitored. Supervision to support staff in their work was understood and implemented informally and formally though the latter was not yet fully extended to all staff given the reliance on relief staff. There was planned training for staff on the administration of insulin and the associated monitoring. The person in charge confirmed that while training was awaited there was a staff available at all times with this training completed.

Judgment: Compliant

Regulation 22: Insurance

There was documentary evidence that the provider was insured against injury to residents and against other risks in the designated centre.

Judgment: Compliant

Regulation 23: Governance and management

There were quality improvement plans that were not fully implemented but the provider had itself identified these areas and was seeking to address them. Therefore the inspector was satisfied that effective management systems were in place to monitor, support and promote the delivery of safe, quality care and services. The actions required for improvement are addressed in the individual regulations.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose contained all of the required information; for example a statement as to the aims and objectives of the centre and the facilities and services to be provided to residents. The record was reviewed and amended to reflect changes such as in the management structure; the record accurately described the service provided.

Judgment: Compliant

Regulation 30: Volunteers

Though there were no volunteers contributing to the support and services provided in this centre, the provider had based on feedback from other HIQA inspections, made available a policy on volunteering. The policy outlined the provider's obligations in relation to adequate and appropriate recruitment, vetting, roles, responsibilities and supervision.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector reviewed records of accidents and incidents that had occurred in the centre during a specified period of 2019. From these records and from speaking with staff, the inspector concluded that there were adequate arrangements for responding to such events and for ensuring that any required notice was submitted to HIQA.

Judgment: Compliant

Regulation 34: Complaints procedure

Records created of complaints received did not provide a record of whether the complainant was satisfied or not that their complaint was appropriately responded to and addressed.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The provider had all of the policies and procedures listed in Schedule 5; all but one of these policies were in date and had been reviewed within a three year time-frame; the policy overdue review related to the creation, retention and general maintenance of records.

Judgment: Substantially compliant

Quality and safety

As discussed in the first section of this report there were areas of the support and services provided, that if addressed would improve their appropriateness and quality. Fundamentally however the inspector found that this was a person centred service where support was provided on an individualised basis. There was evidence of incremental improvements made by the provider and plans for further improvement.

Staff spoken with had ready knowledge of each resident, their needs and changes in these needs and the care and support that they needed on a daily basis for their well-being and development. The inspector then reviewed a purposeful sample of residents' personal plans and found that the plans reflected the needs, preferences, care and support described by staff and also the practice observed. This provided assurance that plans of support and care guided daily practice.

The individuality of these four residents was evident and reflected in the organisation of the service, for example the individual social outings mentioned in the first section of this report and the provision of a self-contained apartment. Residents did mix and interact but could also choose to spend time alone. Individual needs did at times result in times of incompatibility and there were protocols and plans of support to prevent and manage these occasions. Residents were also seen to have voiced at intervals their dissatisfaction with this aspect of living in the centre. It had been established for some-time that the arrangements in the centre were not suited to all resident needs and a low arousal environment was required. There was evidence of environmental changes made to provide a private relaxation-

communal space and there were plans to extend the property further so as to provide a second self-contained personal space. Records seen acknowledged that this would impact positively on the quality of life of all residents. The inspector was advised that the project was now at tendering phase. However, the provider needed to prioritise and finalise the timely completion of these plans so as to optimise the suitability of living in the centre for residents.

In the context of their needs residents did at times present with behaviour of risk to themselves, peers and staff. The inspector saw specific guidelines setting out for staff how to prevent if possible and how to react to these events. These guidelines were evidence based and informed by psychology, behaviour support, consultation with staff and representatives as appropriate. Interventions were also informed by the review of incident records and ABC (antecedent, behaviour and consequences) records maintained by staff. Again staff spoken with clearly described preventative and reactive interventions and the specific role of communication. There was a process for reviewing the effectiveness of the guidelines; the adequacy of the frequency of the review was not however clearly demonstrated based on the records that were available to the inspector.

Effective communication was important in understanding why behaviours presented and how to prevent them but also in the context of sensory needs and the day to day operation of the service. Staff had completed training and used a variety of methods to support effective communication such as manual signing, social stories, visual aids and the Marte Meo method; a solution based programme to support social and emotional communication and development in day to day interactions.

Residents did have healthcare needs and required care and support to maintain and promote their health and well-being; the provider had the necessary arrangements in place. Staff assessed and monitored resident health; staff had detailed care plans to guide their practice and advice and support from the community based nurse. Residents had access to the services that they needed such as their GP (General Practitioner), dentist, chiropodist, speech and language therapist and occupational therapy. Staff worked collaboratively with residents and as appropriate their representatives to promote and ensure resident well-being.

There was evidence to support medicines management practice that promoted resident safety and well-being. The provider had in date policies and procedures to guide practice; prescribed medicines were supplied by community based pharmacies; staff had completed medicines management training; staff maintained records of medicines management practices including their administration. The management of medicines was the subject of regular audit; a recent audit completed by the pharmacist reported satisfactory findings. There was a very low reported and recorded incidence of medicines related incidents.

Resident safety was further promoted by risk management and fire safety systems. The inspector saw that a fire detection and alarm system, emergency lighting and fire fighting equipment were provided, inspected and maintained at the appropriate intervals. Fire resistant door-sets with self-closing devices protected escape routes. Fire safety requirements had evidently been taken into consideration where inner

rooms had been converted to provide bedrooms; these rooms were provided with alternative means of escape directly to the outside or into the main corridor. Staff and residents participated in regular simulated evacuation drills; the drills were scheduled to replicate different scenarios; there were no reported challenges to safe evacuation. The inspector did however recommend consideration of technology designed to alert residents with sensory needs in the event of fire.

The person in charge maintained a register of risks and their management. The inspector reviewed the register and found that it was centre and resident specific. For example the risk posed by needs and personalities that were not always compatible was recognised, assessed and regularly monitored to ensure that risk reducing controls were effective.

Regulation 10: Communication

There was evidence of a broad understanding of how residents communicated; assessment established any communication differences. A variety of tools and programmes designed to support and enhance communication with and for residents were explored and used as appropriate. The importance of communication in the context of other needs and support such as behaviour support was recognised and understood.

Judgment: Compliant

Regulation 13: General welfare and development

Each resident attended structured day services and had opportunity for new experiences, social participation, the experience of work and recreation; residential and day service staff worked together in this regard and in supporting residents to meet their personal objectives. The day service operated from the house some days to best meet individual requirements for perhaps a slower pace or quieter environment. Staff understood the need to continue to support residents to develop their interests and skills, for example daily living skills so that they were enabled to lead their lives in as fulfilling and independent way as possible.

Judgment: Compliant

Regulation 17: Premises

The location, design and layout of the centre were suitable for its stated purpose; further modification was planned and this is addressed in Regulation 5. The house was well-maintained and presented well. Facilities for residents were provided at ground and first floor level; one resident had their own self-contained apartment. Each resident had their own bedroom two of these were en-suite; two further bathrooms, one on each floor were provided. Residents shared communal and dining space and two communal spaces were available in response to residents assessed needs. Residents had access to a garden at the rear of the house.

Judgment: Compliant

Regulation 20: Information for residents

The inspector saw a resident's guide presented in an easy to read format. The record contained all of the required information such as the services provided, how to make a complaint and how to access reports of inspections of the centre.

Judgment: Compliant

Regulation 26: Risk management procedures

Risk management policies and procedures and risk assessments were in place for dealing with situations where resident and/or staff safety may have been compromised. Risks and their management were kept under regular review; the review of incidents informed this oversight of risk and its management. The approach to risk management was individualised and where appropriate supported independence while keeping residents safe from harm.

Judgment: Compliant

Regulation 27: Protection against infection

Practices observed reflected knowledge of current infection prevention and control requirements. The house was visibly clean. Staff had completed infection prevention and control training; wash-hand basins were equipped with soap dispensers and disposable towels; the bins seen were pedal-operated; all of these facilitates support good infection prevention and control practice. Staff were seen to have the required clinical equipment such as single use lancets and proprietary

containers for their disposal; the date of opening was recorded.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had effective fire safety management systems including arrangements for the containment of fire and its products and the safe evacuation of residents in the event of fire.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Each resident was protected by the providers policies and procedures for medicines management.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

It had been established for some-time that the arrangements in the centre were not suited to all resident needs and a low arousal environment was required. Records seen acknowledged that meeting this identified need would impact positively on the quality of life of all residents. The provider needed to prioritise and finalise the completion of its plans for such an environment so as to optimise the suitability of living in the centre for residents.

The adequacy of the frequency of the review of the behaviour support guidelines was not clearly demonstrated based on the records that were available to the inspector.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were supported on an individual basis to achieve and enjoy the best possible health. Staff assessed and monitored residents healthcare needs and provided the care needed so that residents continued to enjoy good health. Staff, residents and families worked collaboratively together. The care provided was evidence based.

Judgment: Compliant

Regulation 7: Positive behavioural support

There was evidence of a therapeutic evidence based approach to the management of behaviour and plans that detailed how therapeutic interventions were implemented. The plan was tailored to individual needs. The plan was seen to be informed by the appropriate multi-disciplinary input, consultation and review with staff and representatives. Staff spoken with had good knowledge of factors that may trigger a behaviour, how to avoid these and how to respond so as to minimise impact.

Judgment: Compliant

Regulation 8: Protection

There were policies, supporting procedures and safeguarding plans for ensuring that residents were protected from all forms of abuse. Staff had completed safeguarding training; staff spoken with had a good understanding of their role in protecting residents from harm and their responsibility to report any concerns they may have; staff understood the reporting procedure.

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
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	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	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for No.5 Fuchsia Drive OSV-0004577

Inspection ID: MON-0022573

Date of inspection: 15/10/2019

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 current roster details 6 staff lines 5 of which are filled by regular staff. The 6th line will be filled with a regular staff by the end of November after the staff has completed her mandatory training. All other staff have their mandatory training and other relevant trainings that are identified to support this group of Residents complete.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The Complaints process has been reviewed by the team i.e. complaints are managed locally where possible. All attempts are to be made to resolve on a timely basis and are signed off by the PIC. The Person in Charge will follow up older complaints to ensure that have been appropriately responded to and addressed by 8th November 2019.	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: The national policy on records management has been reviewed in November 2019 and the updated version is due for circulation in December 2019.	

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:
There is a planned development of an apartment accommodation for one person supported. This development aims to offer separate apartment-style living and further enhance the quality of life of all residents in the house.

The development has been sanctioned financially and the PIC will meet with family and MTD Team in advance of commencement of works.
An application for the registration of this development will be submitted to the Authority.
There is a nine-week building plan to complete this work, which should be completed by 31/3/2020.

A report of the behaviour support consultation of 5/9/19 is now on the resident's file.
The Periodic Service Reviews (PSR's) for individual's Behaviour Support Plan will continue on a 3 monthly basis, coordinated by the keyworker and overseen by the Person in Charge.

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	16/12/2019
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	08/11/2019
Regulation 04(3)	The registered	Substantially	Yellow	16/12/2019

	provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Compliant		
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/03/2020
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	05/09/2019