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:	Delta Evergreen
Name of provider:	Delta Centre Company Limited by Guarantee
Address of centre:	Carlow
Type of inspection:	Unannounced
Date of inspection:	23 May 2019
Centre ID:	OSV-0004708
Fieldwork ID:	MON-0021328

About the designated centre

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

Delta Evergreen is a residential designated centre situated in Carlow town. Residents living in the centre are male and female adults and have an intellectual disability. All residents need a level of support. The centre comprises of three houses Tintean Blackbog, Teach Sonas and Tintean Coille 1&2. The centre strives to ensure that the rights of each individual resident are upheld, including a right to equality, dignity, respect, privacy and safety. The centre also strives to ensure that each resident can be supported to maintain a sense of individual identity and ownership of their own lives. The service is available 24/7. Staffing consists of social care workers and healthcare assistants. Nursing care is also available when needed. All of the residents living within these community residential settings have daily access to Delta Centre Ltd campus in Carlow. Residents also have access to a wide range of community based social activities.

The following information outlines some additional data on this centre.

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
23 May 2019	10:00hrs to 17:00hrs	Sinead Whitely	Lead

Views of people who use the service

The inspectors had the opportunity to meet and speak with six residents on the day of inspection. In general, the residents expressed their high level of satisfaction with the service being provided. Residents appeared happy and comfortable in their home and in each others company.

Two residents spoke about individual community based activities they had taken part in. These included going bowling in the the local activity centre and going for a drink or coffee with friends. Residents showed the inspectors awards they had won while partaking in the Special Olympics and two residents showed the inspectors around their home in one house. Residents appeared proud of their space and happy in their home.

The inspectors observed residents going about their daily routines and activities on the day of inspection. These included going to and from day services and work. Residents and staff appeared at ease in each others company and warm and positive interactions were observed between staff and residents.

Two residents communicated a complaint with the inspectors regarding the availability of the service vehicle on two days of the week. This was impacting on the residents preferred activities on these days. One residents also expressed a complaint regarding food arrangements in the house. The provider was not aware of these complaints on the day of inspection prior to the residents communicating them with the inspectors.

Capacity and capability

Overall, the provider appeared to be striving to provide a safe service to the residents living in the designated centre. All actions from the previous inspection had been addressed. Persons participating in management, the person in charge and support staff were endeavouring to promote a person centred service, guided by the residents living there. Some improvements were needed in audit systems being utilised to ensure that all areas in need of improvement were being identified by the provider.

There was a clear management system in place with lines of accountability. The person in charge was on annual leave on the day of inspection, and it was evident that robust systems were in place in their absence with another member of management supporting staff and residents for the duration of their leave. Regulation based six monthly audits were being completed by a person

nominated by the provider. The results of these were shared with the management team and an action plan in place. There was a member of management on-call outside of regular working hours, should staff need further support. Team meetings were held on a regular basis to discuss any ongoing issues in the centre.

There was no annual review of the quality and safety of care and support being provided for 2018 completed on the day of inspection. This had been highlighted in the centre six monthly audit but no action plan had been put in place for a date of completion. Furthermore, audit systems in place were not always identifying all areas in need of improvements at times. This was evident through the inspections findings.

Staffing levels and skill-mixes were meeting the assessed needs of the residents living in the designated centre. The staff team consisted of social care workers and healthcare assistants. Nursing support was also available in the service if needed. There was a planned and actual staff roster in place that accurately reflected the staff on duty. There was an internal relief panel in place to cover any staff sickness or leave. This promoted continuity of care during these times. Staff spoken with appeared to have good insight and understanding of the residents social, personal and healthcare needs. The inspector reviewed a sample of staff files and found that the majority of Schedule 2 documents were in place as required. However, it was noted a number of staff members did not have an up to date contract of work in place.

The registered provider was ensuring that there was a training program in place and staff had access to training as part of a continuous professional development programme. This included training in fire safety, manual handling, epilepsy management, safeguarding, medication management, and infection control. Training being provided was guiding the provision of a good standard of care. Regular one to one staff supervisions and performance reviews were being completed by the person in charge. The template being utilised was identifying any areas in need of improvement. However,following a review of training records it was identified that one staff member had not completed training in fire safety on the day of inspection, furthermore five staff members were due refresher training.

Overall, the inspector found that complaints were treated in a serious and timely manner. A sample of the centres complaints records were reviewed. The service policy in place was guiding practice in the event of a complaint being communicated with staff or management There was a complaints procedure available in a version accessible to the residents and this was prominently displayed in the designated centre. There was a designated officer in place to process any complaints received.

Two residents communicated a complaint with the inspectors regarding the availability of the service vehicle on two days of the week. This was having an impact on the residents partaking in their preferred activities on the evenings the vehicle was not available to them. Following a review of the number of service vehicles available and the number of designated centres, it was found that

there were an inadequate number of service vehicles provided to meet the needs of the residents. One residents also expressed a complaint regarding food arrangements in the house. The provider was not aware of these complaints on the day of inspection prior to the residents communicating them with the inspectors. No other complaints were communicated with the inspectors on the day of inspection.

Regulation 15: Staffing

In general, staffing levels and skill-mixes were meeting the assessed needs of the resident. There was a planned and actual staff rota in place that accurately reflected staff on duty on the day of inspection. However, it was noted a number of staff members did not have an up to date contract of work in place.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The registered provider was ensuring that there was a training program in place and staff had access to training as part of a continuous professional development programme. However,following a review of training records it was identified that one staff member had not completed training in fire safety on the day of inspection, furthermore five staff members were due refresher training.

Judgment: Not compliant

Regulation 23: Governance and management

There was a clear management system in place with lines of accountability. However, there was no annual review of the quality and safety of care and support being provided for 2018 completed on the day of inspection. Furthermore, audit systems in place were not always identifying all areas in need of improvements. This was evident through inspection findings.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Overall, the inspector found that complaints were treated in a serious and timely manner. However, two complaints were communicated with inspectors on the day of inspection. The provider was not aware of these complaints.

Judgment: Substantially compliant

Quality and safety

Overall, the provider, persons participating in management and the person in charge were striving to promote and provide a safe service to the residents. Residents were safeguarded and were supported to maintain their health to a high standard. Some areas in need of improvement were noted on the inspection.

The registered provider had ensured that the designated centre was being operated in a manner that supported residents rights. Residents had the freedom to exercise choice and control in their daily lives. Residents were consulted and had the opportunity to participate in the organisation and running of the designated centre. The inspectors observed evidence that residents had been supported to vote in local referendums and details of advocacy service were available in the designated centre.

The registered provider was ensuring that the residents felt safe and were safeguarded. Residents voiced to the inspectors that they felt safe on the day of inspection, when asked. All staff were trained in the safeguarding and protection of vulnerable adults. Staff spoken with appeared knowledgeable regarding service policy and the national safeguarding policy. There was a designated officer in place to process any concerns raised. One inspector had the opportunity to meet and speak with the service safeguarding officer on the day of inspection. It was evident that any incident, allegation or suspicion of abuse was treated seriously and investigated appropriately in line with national policy. There was an intimate care plan in place that guided staff practice to deliver care in a manner that respected the residents dignity. Safeguarding plans and measures were in place where appropriate and any allegations or incidents had been notified to the Office of the Chief Inspector.

The person in charge was ensuring that the designated centre was suitable for the purpose of meeting the needs of the residents. All residents had a comprehensive assessment of need and personal plan in place that was guiding care. These were subject to regular review and reflected the residents individual needs. There was a key-worker system in place. While social goals were implemented, some improvements were needed to ensure that goals were person centred, relevant to the residents most current needs and guided the residents personal development. Particularly in areas including personal care, dressing and dietary requirements. Inspectors also noted that some goals had not been updated in the time frames set out.

Residents were supported to partake in person centered activities, these included bowling in the local activity centre, attending the local gardens and day service, going for coffee or drinks with friends, holidays and partaking in the Special Olympics .Two residents communicated that the service vehicles were not always available to them when needed. This was the case on two days of every week and residents voiced that this prevented them from taking part in their preferred activities on the days affected. Following a review of the service vehicles available, along with the number of centres, it was found there was an inadequate number of vehicles in place to meet the assessed needs and preferences of the residents.

Overall, the inspectors found that the residents were supported to maintain their health to a high standard. Staff were making referrals when necessary to allied healthcare professional and when medical treatment was recommended, such treatment was facilitated. Plans in place with details of recommendations made by speech and language therapists, occupational therapists and dietitians were reviewed. The residents had access to nursing support if required. Staff spoken with were familiar with the residents individual medical needs. A pre-screening program for age related illness was in place for all residents. The person in charge had ensured that appropriate supports were in place for residents at times of illness that met their physical, emotional and spiritual needs and respected their dignity, autonomy and wishes. There was a checking system in place for each resident in their personal file to ensure that healthcare needs were reviewed on a regular basis. This included attending national health screening appointments, regular bloods, hearing checks, visual checks, vaccines, dental care and regular general practitioner (GP) reviews. Plans were in place to accurately guide staff to administer medication as required (PRN).

Inspectors found that in general, residents were being supported to manage their behaviours when needed. Positive behavioural support plans were in place where appropriate, and staff spoken with had good understanding of the residents individual needs supports necessary to alleviate causes of challenging behaviours. Restrictive practices were minimal in the centre and only utilised when a risk was posed to the resident. Risk assessments were in place to evidence this and these were subject to regular review. Any restrictive practices in place had been notified to the Office of the Chief Inspector as required. Some evidence of therapeutic interventions being utilised were observed, in particular a low arousal approach. However, plans in place these had not been reviewed in a considerable period of time. One plan observed had not been reviewed in over two years. Access to behavioural specialists was limited, and the need for further input was evident in some residents daily records. Staff had not completed and did not have access to training in positive behavioural support.

Following a review of a sample of medication prescriptions and the centre medication storage facilities, it was identified that some improvements were needed to ensure that practice relating to the ordering, prescribing, storage, disposal and administration of medicines was safe and in line with best practice. A sample of residents medication administration records were reviewed and it was found that not all administrations were recorded appropriately with some gaps evident on numerous dates. There were arrangements for the safe storage of medication in a

locked storage unit. It was observed there was no arrangements for the safe separate storage of out-of-date or unused medication. The inspectors acknowledge that this was rectified on the inspection day with a separate safe locked box brought to the centre for this purpose later in the day.

The residents medication prescriptions were clear and were subject to annual review and signed by a general practitioner (GP). However, maximum drug dosages were not always indicated on documentation guiding the administration for medicines being used as required (PRN). Furthermore, the administration route outlined for one drug was incorrect. A sample of residents medicines were reviewed and all drugs were found to be within their expiry dates, however it was observed that some drugs did not have their expiry dates evident on the packaging. This increased the risk of medicines that were out-of-date being administered to residents. Staff were suitably trained in the safe administration of medication. Self administration assessments had been completed for all residents.

There were robust systems in place in the designated centre for hazard identification and the assessment, management and ongoing review of risk. There was a risk register in place that adequately recorded any identified risks in the designated centre. Any risk identified were then suitably assessed and appropriate measures were then put in place to mitigate the identified actual or potential risk. There was a risk management service policy in place that appeared to be guiding staff practice. There were arrangements for response in the event of an emergency. Risk assessments were individualised when appropriate.

In general, the registered provider had ensured that the premises was designed and laid out to meet the needs of the residents living there. The designated centre comprised of three houses. One house was being re-furbished on the day of inspection and was not suitable for use. The remaining two houses were of sound construction and kept in a good state of repair. The premises appeared clean and suitably decorated. Sleeping accommodation was provided separately and residents had the opportunity to decorate their space to their own individual preferences. A conservatory and garden areas were available to residents to sit out in during warming weather. The inspectors observed adequate space and suitable storage facilities provided for residents. However, some outstanding decor issues were noted in one house. This included worn carpeting, chipped paintwork and a broken washing machine.

Overall, the registered provider had ensured that effective fire safety management systems were in place. Staff and residents were completing regular evacuation drills and regular daily and weekly checks on doors, exit routes, lighting and equipment. There were personal emergency evacuation plans (PEEP) in place for all residents and there was a centre emergency evacuation plan in place for staff and residents. Any fire equipment was being serviced regularly by an external company. Appropriate emergency lighting was in place around the centre to guide exit routes in the event of a fire. However, adequate containment measures were not in place in one house in the designated centre. This was discussed in further detail during the feedback session at the close of inspection.

Regulation 26: Risk management procedures

There were robust systems in place in the designated centre for hazard identification and the assessment, management and ongoing review of risk.

Judgment: Compliant

Regulation 28: Fire precautions

In general, the registered provider had ensured that effective fire safety management systems were in place. However, adequate containment measures were not in place in one house in the designated centre. This was discussed in further detail during the feedback session at the close of inspection

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

In general, improvements were needed to ensure that practice relating to the ordering, prescribing, storage, disposal and administration of medicines was safe and in line with best practice

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The person in charge was ensuring that the designated centre was suitable for the purpose of meeting the needs of the residents. However, some improvements were needed to ensure that social goals were person centred, relevant to the residents most current needs and guided the residents personal development.

Judgment: Substantially compliant

Regulation 6: Health care

Overall, the inspectors found that the residents were supported to maintain their health to a high standard. Staff were making referrals when necessary to allied healthcare professional and when medical treatment was recommended, such treatment was facilitated. The residents had access to nursing support if required

Judgment: Compliant

Regulation 7: Positive behavioural support

Overall, the inspectors found improvements were needed in positive behavioural support. Positive behavioural support plans were in place, however these had not been reviewed in a considerable period of time. Access to behavioural specialists was limited. Staff did not have access to training in positive behavioural support.

Judgment: Not compliant

Regulation 8: Protection

The registered provider was ensuring that the residents felt safe and were safeguarded. Residents voiced to the inspectors that they felt safe, when asked. All staff were trained in the safeguarding and protection of vulnerable adults.

Judgment: Compliant

Regulation 17: Premises

In general, the registered provider had ensured that the premises was designed and laid out to meet the needs of the residents living there. One house was being refurbished on the day of inspection and was not suitable for use. Some outstanding decor issues were identified in one house. This included worn carpeting, chipped paintwork and a broken washing machine

Judgment: Substantially compliant

Regulation 9: Residents' rights

The registered provider had ensured that the designated centre was being operated in a manner that supported residents rights. Residents had the freedom to exercise

choice and control in their daily lives
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	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Delta Evergreen OSV-0004708

Inspection ID: MON-0021328

Date of inspection: 23/05/2019

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 15: Staffing</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 15: Staffing:
All staff will have a contract on their personnel files.
Staff members who commenced employment pre-March 2019 were supplied with contracts, but some have declined to sign these on the advice of FORSA union. Any staff employed from March 2019 are required to sign the contracts of work before commencing employment. Delta Services are unable to enforce the signing of contracts to any staff employed pre-March 2019 and this matter has been discussed with the WRC in January 2019.
This judgement was responded to in the feedback form and submitted to HIQA via email within 15 working days of receiving the report.</td></tr>
<tr><td>Regulation 16: Training and staff development</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Staff member that had not completed fire training ceased employment from the 18th-06-2019.
Refresher training is booked for 31st July 2019.
Challenging behavior training is taking place on 23rd and 24th September 2019.</td></tr>
</table>

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The 2018 Annual Review for Delta Evergreen has been completed and was submitted via email on 7/7/2019.
The audit system will be reviewed and restructured to make the system "SMART", this process will be completed by 31st of December 2019.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The complaint received on the day of the inspection was followed up by the PIC and logged on the complaints log. Additional transport is available within the same housing estate that can be availed of and the complaint in relation to food arrangements was previously received by the PIC in October 2018 and documentation regarding the handling of the complaint is available in the complaints log (Which was viewed on the day of inspection) The complaint was closed at this time which was agreed with the resident and their family representative. Arrangements were made to ensure that the resident food planning requests are met and food they requested is purchased weekly.
The resident chooses at times not to follow their chosen diet plan and this has also been observed by the external auditor for Delta Services whilst conducting their audit. The resident's rights to choice mean that staff will continue to support them to follow the food plan they wish however they cannot impose the plan particularly as it is not a medically necessary dietary restriction.
This judgement was responded to in the feedback form and submitted to HIQA via email within 15 working days of receiving the report.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Housing association contacted, and the doors will be replaced to include self-closing hinges.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Review of prescription sheets, system adjusted so nay missed doses are recorded and explanation for same recorded.

PRN medications to describe maximum doses.

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:
All person-centred plans are developed with individual residents to ensure person centredness, residents choose goals which they would like to achieve themselves. Residents are encouraged to work towards achieving approx. 3 goals at a time particularly if they attend services less than 5 days per week. Any more than this can become overwhelming and unachievable. Staff assist them through the process to try and ensure that goals are developmental in nature. If relevant and the resident chooses to then these goals can include personal care etc. Minutes are available of the PCP meetings and are signed by the residents also. Annually a meeting is conducted with family members or advocates, the minutes of these meetings are also available in the individual person-centred plan. On the day of the inspection it was discussed that one resident present in Coille 1 & 2 was wearing tracksuit bottoms and black shoes and the inspector felt this attire was not fully suitable and that perhaps runners would be better however the resident is required to wear orthotic footwear and prefers to wear shoes, the resident also chooses to wear black tracksuit bottoms daily and has done for many years regardless of staff or family encouragement.
This judgement was responded to in the feedback form and submitted to HIQA via email within 15 working days of receiving the report.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The organisation continues to seek the assistance of a behavioural therapist, in the interim, approaches to challenging behaviour training has been booked for 23rd and 24th September 2019.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The areas discussed on inspection will be rectified by 31-11-19. Carpet will be replaced and kitchen will be painted.	

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(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	31/03/2020
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.	Not Compliant	Orange	24/09/2019
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair	Substantially Compliant	Yellow	30/11/2019

	externally and internally.			
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.	Substantially Compliant	Yellow	31/12/2019
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	07/07/2019
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/11/2010
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	Not Compliant	Orange	31/08/2019

	medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.			
Regulation 29(4)(c)	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 out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.	Substantially Compliant	Yellow	24/05/2019
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Substantially Compliant	Yellow	30/06/2019
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the	Substantially Compliant	Yellow	30/06/2019

	designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	24/09/2019
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.	Not Compliant	Orange	24/09/2019
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning	Substantially Compliant	Yellow	24/09/2019

	process.			