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:	Centre A2
Name of provider:	Peamount Healthcare
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	04 July 2019
Centre ID:	OSV-0005387
Fieldwork ID:	MON-0023403

About the designated centre

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

The designated centre is comprised of three individual units and is based on a shared campus setting in an area of rural West County Dublin. It provides 24 hour residential support services to persons with intellectual disabilities and at the time of inspection was supporting 12 individuals. The three units of the centre had similar layouts and included an entrance hallway, a living and dining room, a small kitchen area, accessible bathrooms and individual bedrooms for residents. The staff team was comprised of a newly appointed person in charge, a clinical nurse manager, staff nurses, carers and household staff members.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

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
04 July 2019	09:00hrs to 17:00hrs	Thomas Hogan	Lead
05 July 2019	10:00hrs to 13:45hrs	Thomas Hogan	Lead

Views of people who use the service

The inspector met with a number of residents who were availing of the services of the centre and observed care and support being delivered by staff members. Residents appeared satisfied with the care and supports that they were receiving and in conversations expressed to the inspector that they were happy and felt safe residing in the centre.

Capacity and capability

Overall, the inspector found that this centre presented with very mixed findings across the regulations inspected against. While in some cases there were examples of good care and support being provided to residents, in other instances the inspector found that services were provided through an institutionalised approach. Residents were found to experience a quality of life which on occasions was limited due to this institutionalised approach by the registered provider. A person-centred culture was not in place in this centre and a number of institutionalised practices were observed by the inspector during the course of this inspection. These included a number of staff wearing uniforms, the use of centralised kitchens, a high level of staff footfall through residents' homes, the use of walkie-talkies by staff which interrupted and limited opportunities for normal living for residents, and the absence of sustained aspirations for the creation of valued social roles for residents in their local communities. While some efforts were made in the time since the last inspection, overall it was found that sustained improvements had not been achieved in this area by the registered provider.

The inspector met with the person in charge on the second day of the inspection. The person in charge had recently taken up the position and was found to meet the requirements of the regulations. They demonstrated appropriate knowledge and awareness of the relevant legislation, regulations and national policy.

A review was completed of staffing arrangements and the inspector found that while there were sufficient numbers of staff employed in the centre, the skill mix of the staff team did not reflect the need of residents or the aims and objectives of the centre which were set out in the statement of purpose. In the time since the last inspection, the number of staff members employed was found to have increased and staff members spoken with outlined the positive impact this had on the quality of care and support being delivered to residents. The inspector found; however, that while there were regular reviews being completed of staffing numbers deployed in the centre, these assessments did not include a skill mix review. The inspector found that one contributory factor to the social care needs of residents remaining generally unmet was the experience, skills and training of the staff team. Despite this finding,

the inspector observed staff members treating residents with kindness and respect and attending to their needs in a timely manner throughout the period of the inspection.

A review of a sample of staff duty rosters found that both 'planned' and 'actual' rosters were maintained. The shift leader was not clearly identifiable on these documents; however, and both start and end times of shifts were not clearly communicated. In addition, a number of codes used on the rosters were not explained or a key provided to outline their meaning. A sample of four staff files were reviewed and were found to contain all required information set out in schedule 2 of the regulations.

The inspector reviewed staff training records and found that there were deficits in four areas of training identified as being mandatory by the management team. The clinical nurse manager had put in place a training plan to address the majority of these deficits prior to the time of inspection. A review of staff supervision arrangements found that staff members were not in receipt of formal one-to-one supervision meetings in line with the frequency detailed in the organisation's policy on this matter.

The governance and management arrangements of the centre were reviewed by the inspector as part of the inspection. There had been a number of changes in key management positions both within the centre and wider organisation in the time since the last inspection. Annual reviews and six monthly unannounced visits by persons on behalf of the registered provider had been completed and in addition, a suite of audits had been completed locally. Despite this, the inspector found that there was a clear need for improved oversight of the care and support being delivered to residents through the services of the centre. For example, the registered provider had not identified through their own auditing and review mechanisms that there was a need to develop services to meet the social care needs of residents or to improve on medication management processes to ensure that all medications were administered as prescribed and recorded as such. In addition, through a review of staff files, the inspector found that the registered provider had not appropriately investigated a matter in line with organisational or national policy which had arisen relating to a staff member.

A review of a sample of incident and accident records was completed by the inspector and it was found that notifications had appropriately been made to the Office of the Chief Inspector (OCI) as required by the regulations. In addition, the inspector found that the management team in place in the centre were very aware of their responsibilities regarding notifications as outlined in legislation, regulations and national policies.

Regulation 14: Persons in charge

The inspector found that the person in charge had the appropriate qualifications, skills and management experience to oversee the delivery of safe care and support

to residents.

Judgment: Compliant

Regulation 15: Staffing

- The inspector was not assured that there was an appropriate skill mix present amongst the staff team to meet all residents' needs and to meet the aims and objectives of the centre as outlined in the statement of purpose.
- A review of a sample of staff duty rosters found that shift leaders were not clearly identifiable, start and end times of shifts were not clear, and codes used on the documents were not explained.

Judgment: Not compliant

Regulation 16: Training and staff development

The inspector identified that there were deficits in an number of training areas which were described as being mandatory by the person in charge. These were as follows:

- one staff member had not completed training or refresher training in manual handling
- two staff members had not completed training or refresher training in practical hand hygiene
- one staff member had not completed training or refresher training in infection control
- one staff member had not completed training or refresher training in safeguarding vulnerable adults from abuse

In addition, the arrangements in place for the formal supervision of staff were not satisfactory as staff members were not in receipt of one-to-one supervision in line with organisational policy.

Judgment: Substantially compliant

Regulation 23: Governance and management

A need for improved oversight was identified to ensure that appropriate care and support was being delivered to residents. The registered provider was found to have

failed to self-identify areas of concern and non-compliance through auditing and review mechanisms.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspector reviewed a sample of incident and accident records for 2019 and found that notification had appropriately been made to the OCI in all cases.

Judgment: Compliant

Quality and safety

A review of the arrangements in place to support residents with their general welfare and development found that overall, they were not experiencing the best possible quality of life as a result of the approach taken by the registered provider. Residents' needs were not clearly assessed or identified and there was an overall absence of appropriate supports in place to meet their social care needs. A review of 'meaningful activity' records maintained for a number of residents found that they were supported to engage in very few activities which were truly meaningful. For example, in the cases of some residents, 'meaningful activities' listed as having been completed included household chores, personal care, "grooming", the completion of fire drills, colouring, and completing a jigsaw. The vast majority of activities available to residents were unit and centre based and residents were infrequently supported to engage in activities outside their residential campus setting. The inspector reviewed a random sample of four resident files and found that in two cases residents had not been supported to engage in any activities outside the campus setting in the four weeks preceding the inspection.

The inspector completed a walk through of all areas of the centre in the company of the clinical nurse manager and found that it was clean, decorated to a satisfactory standard and well maintained throughout. All residents had individual bedrooms and there were adequate numbers of bathrooms and shower rooms. All areas of the centre were fully accessible for the individuals using its services.

The centre's risk policy was reviewed by the inspector and was found not to contain a number of areas outlined as being required by the regulations.There was a risk register in place and it was found to have assessed all presenting risks in the centre. There was appropriate oversight of all incidents and accidents which had occurred and satisfactory responses and follow up actions were recorded in all documentation which was sampled.

There was a fire alarm and detection system in place and emergency lighting had been fitted to required areas of the centre. All staff had completed fire safety training and fire drills were completed on a regular basis and included the participation of residents. The fire alarm and detection system and the emergency lighting were found to have been serviced by appropriate personnel on a regular basis. Residents had individual personal emergency evacuation plans in place which reflected their support needs in the event of a fire or similar emergency. Fire doors had been fitted to all areas of the centre in the time since the last inspection; however, self-closing mechanisms had not been installed on these doors as required.

A review of medication management arrangements found that in a number of cases prescribed medication had not been signed as having been administered to residents. This was identified in three of four residents medication administration records which were reviewed by the inspector. Incident forms were found not to have been completed prior to this matter being identified by the inspector. Medication was found to have been securely stored in the centre, and a sample of medications reviewed were all within their stated expiry dates. Capacity assessments had been completed for all residents in relation to the self-administration of medications and the inspector found that there were appropriate arrangements in place for the storage and disposal of out-of-date and spoiled medication.

Assessments and plans which had been completed for residents were reviewed by the inspector. It was found that while there were some assessments completed, overall, residents did not have a comprehensive assessment of all of their needs completed. Those which were available were focused exclusively on the medical needs of residents and there was an absence of evidence available to demonstrate that these limited assessments were completed on at least an annual basis. It was not clear having reviewed these documents what the identified needs of residents were. Similarly, while there were a wide variety of personal plans in place for residents, it was not clear how the needs being addresses in some of these documents had been identified. Plans were based on a medical approach to care and support and did not extend to the social care needs of residents. There was an absence of evidence to demonstrate that the personal plans in place were reviewed at least annually in a multi-disciplinary context, were reviewed for their effectiveness and were updated to reflect the changes in circumstance of residents.

The inspector found that appropriate supports were in place to support residents with behaviours of distress. Residents who required positive behavioural support plans had these in place and they were found to provide clear direction to staff members on how residents should be supported in a proactive and reactive manner. While there were a number of restrictive practices in place in the centre, the inspector found that all restrictions had been identified by the registered provider and were listed on a centralised restrictive practice log.

Staff members and the management team were found to have satisfactory awareness of the types of abuse and the actions which were required to be taken in the event of witnessing or suspecting abuse. The inspector observed that the staff and management team placed a strong focus on promoting the protection of

residents and ensuring their safety. A review of incidents and accident records and follow up actions taken found that national policy was being appropriately applied to the management of safeguarding matters in the centre.

Regulation 13: General welfare and development

- The registered provider was found to have failed to provide appropriate social care supports to all residents in the centre.
- The inspector found that there were limited opportunities provided for residents to engage in occupational and recreational activities of a meaningful nature.
- Arrangements were not in place to support residents to develop and maintain natural support networks though community engagement.
- The vast majority of activities which residents were supported to engage in were centre and unit based and as a result, the inspector found that the registered provider had failed to provide opportunities which reflected the capacities of individuals.

Judgment: Not compliant

Regulation 17: Premises

The inspector found that the centre was homely, accessible and was decorated tastefully in line with the expressed wishes of residents.

Judgment: Compliant

Regulation 26: Risk management procedures

A risk management policy in place in the centre did not contain a number of areas identified by the regulations as being required which were

- the measures and actions in place to control the following specified risks:
    - the unexpected absence of any resident
    - accidental injury to residents, visitors and staff
    - aggression and violence
    - self-harm
- the arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents and
- the arrangements to ensure that risk control measure are proportional to the

risks identified, and that any adverse impact such measures might have on the residents' quality of life have been considered.

Judgment: Not compliant

Regulation 28: Fire precautions

Self-closing mechanisms had not been installed on fire doors fitted in the centre.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

In the cases of three residents, the inspector found that records were not maintained to demonstrate that medications had been administered as prescribed on a number of occasions in the time period sampled.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

- Assessments of need which were completed were not comprehensive in nature.
- Assessments were not completed on an annual basis and it was unclear what identified needs arose from the assessment process.
- Personal plans were limited to mainly medical matters and were not in place to support residents with social care needs.
- Plans were not reviewed on an annual basis and the there was an absence of evidence to demonstrate that there was a multi-disciplinary approach to reviews.
- The effectiveness of plans was not included in the review process.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The inspector found that the staff team had up to date knowledge and skills to

respond to behaviours of distress and to support residents to manage their behaviours.

Judgment: Compliant

Regulation 8: Protection

Appropriate responses and follow up actions were taken in response to incidents of a safeguarding nature and both the staff and management team demonstrated a clear understanding of their roles in adult protection.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Centre A2 OSV-0005387

Inspection ID: MON-0023403

Date of inspection: 05/07/2019

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A Social Care Manager (SCM) has been appointed and has commenced in post on the 01/08/2019. This appointment will address the skill mix in the centre. The SCM will support the PIC in implementing a plan that will enhance the delivery of the social care needs of the centre. Colour coding has been introduced on rosters clearly identifying the shift leader, along with night duty, day shifts and annual leave. Shift start and end times are in the 24 hour clock, and a key explaining the codes has been placed on the roster.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The person in charge in Centre A2 will monitor the training tracker to ensure that it is up to date and all training is completed by staff. There is a training plan in place and staff are booked on training by the HR department, staff are notified of their training by their HR business partner. Since inspection the following training has been completed: Manual Handling: is currently at 100% Practical Hand Hygiene: 2 Staff members are out of date in Practical hand Hygiene, 1 Staff Nurse has been trained as a trainer in Practical Hand Hygiene and will deliver hand hygiene training to all	

staff in centre A2 in need of refresher before the 31/08/2019.

Infection Prevention and Control:
2 staff members will have completed Infection Prevention and Control by the 31/08/2019
Safeguarding Vulnerable Adults: is currently at 100%

Supervision:
A supervision tracker and supervision attendance record is now in place to ensure that all staff supervision and development is in line with the organizations policy.
12 staff members have had supervision this year to date, a calendar is in place for the remaining 7 staff for supervision by 31st December 2019.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The provider has undertaken a full audit of the Medication management in the centre. The outcome of this audit will be actioned by the PIC with support from her ADON.

The Provider will ensure that annual reviews and six-monthly unannounced visits to the center are maintained, and that a plan is put in place to address any concerns regarding the quality and safety of care that arise.
All actions from reviews will be supervised by the ADON and DON until they are closed out.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
A Social Care manager has commenced in post on the 01/08/2019. The SCM will support the PIC in implementing a plan that will enhance the delivery of the social care needs of the centre.
A Review of individual goals to ensure they are person centered to meet the residents will and preference will be completed. The person in charge together with the MDT will continue to assess the supports required for each resident to meet their goals.
The assistant director of nursing has undertaken a review of other social care facilities, and will develop a training programme for the staff on social care to further enhance

their person centred practice. Registered nurses are supported to undertake further training, Aging Health and well-being in Intellectual Disability. The person in charge will utilise the experience of a variety of stakeholders including Professor McCarron (TCD) who will deliver a presentation for all staff on the 20th August 2019 in Peamount.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The Integrated Risk Management Policy has been revised to include measures and actions to control specified risks in line with Regulation 26 and will be implemented week commencing 12th August 2019. All risk assessments in the centre will be reviewed to ensure that the control measures are proportionate.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: A costed plan will be sent to the HSE for self closing mechanisms for the doors in the centre, and we await the allocation of funding to complete this work. This will be sent by 12th August 2019.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: The Pharmacy department will conduct audits on site to ensure compliance with medication management policies and procedures. The person in charge will share audit results with staff in centre A2 to ensure learning from audit results. The admistration practice in this centre will be monitored by the PIC. This will include daily check of the Kardex when the PIC is on duty.

The ADON of the service together with Practice Development have organized to meet with the nurses in the centre to address the concerns around the administration practice in the centre and the accountability of the individuals concerned.

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:
A social care manager has commenced in post on the 01/08/2019, the social care manager will work with the person in charge to drive social care in centre A2.
We are reviewing documentation from other centres, and plan to implement a care planning system that meets the needs of the residents. We recognize that our current system is medicalised and needs to be modified to met their social needs.
Currently a review will take place of all our care plans to address the following:
• Assessment of needs to ensure that they are current and that the relevant member of MDT is involved.
• Monitor the effectiveness of the plans in a timely manner.
• The residents will be supported to take part in activities according to their will and preference whether this on campus or off campus.
The multidisciplinary team annual review plan is to coincide with care plan reviews to ensure they are reflective of the residents needs both medically and socially.
Multidisciplinary team recommendations will be included in the care planning process.
The interest checklist will be reviewed for all residents to ensure that they are still relevant and meaningful.
Any care plan audits that are undertaken in the centre the recommendations will be actioned by the PIC.

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 13(1)	The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.	Not Compliant	Orange	31/01/2020
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Orange	31/12/2019
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in	Not Compliant	Orange	31/12/2019

	accordance with their interests, capacities and developmental needs.			
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Not Compliant	Orange	31/12/2019
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.	Not Compliant	Orange	31/08/2019
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	31/08/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training,	Substantially Compliant	Yellow	30/08/2019

	as part of a continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	01/01/2020
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	30/09/2019
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.	Not Compliant	Orange	31/12/2019
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified	Not Compliant	Orange	31/08/2019

	risks: the unexpected absence of any resident.			
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: accidental injury to residents, visitors or staff.	Not Compliant	Orange	31/08/2019
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: aggression and violence.	Not Compliant	Orange	31/08/2019
Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: self-harm.	Not Compliant	Orange	31/08/2019

Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Not Compliant	Orange	31/08/2019
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Not Compliant	Orange	31/08/2019
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/01/2020
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre	Not Compliant	Orange	30/09/2019

	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.			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	31/12/2019
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the	Not Compliant	Orange	31/03/2020

	resident's personal development in accordance with his or her wishes.			
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	31/12/2019
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	31/12/2019