Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of designated centre:	Ardeevin
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	06 December 2018
Centre ID:	OSV-0005777
Fieldwork ID:	MON-0024990

About the designated centre

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

Ardeevin designated centre provides community based living arrangements for up to four adult residents. Ardeevin is a modern and spacious property that provides residents with a high standard living environment which meets their assessed mobility and social care needs. Each resident has their own bedroom. This service provides supports for residents with severe to profound intellectual disabilities and complex needs. The provider identifies that residents living in this centre require high levels of support and has staffing arrangements in place to ensure residents needs are met. There is a full-time person in charge assigned to the centre, three staff during the day to support residents in having a full and active life and one waking night staff in place also. The centre is resourced with one transport vehicle to support residents' community based activities. Ardeevin is a recently opened designated centre as part of Saint Patrick's Centre overall de-congregation from the main congregated setting campus.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

To prepare for this inspection the inspector or 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
06 December 2018	10:30hrs to 18:00hrs	Ann-Marie O'Neill	Lead

Views of people who use the service

The inspector met with all four residents living in Ardeevin designated centre. Residents were unable to provide feedback to the inspector about the service they received. The inspector spent time with residents while they did some colouring and listening to music. Throughout the inspection, the inspector observed residents' daily routines and interactions with staff. Residents appeared content, relaxed and happy in their new home. Staff encouraged them to participate in chores during the day and residents were also observed leaving the centre during the day to attend to activities within the community and also to attend a farewell party for one of their peers living on the campus of Saint Patrick's Centre. Staff were observed to engage with residents in a kind and attentive way. Residents were observed smiling throughout the day and appeared to thoroughly enjoy their home cooked meals and snacks prepared by staff.

Capacity and capability

The provider had systems in place to ensure the centre was regularly monitored and reviewed from a provider level. Inspection findings demonstrated the provider was implementing consistent monitoring and oversight of the service which in turn was providing residents with a good quality of life and safe, person centred care which met their assessed needs.

A clearly defined management structure was in place which ensured lines of accountability and authority within the centre. The person in charge had responsibility for this designated centre only at the time of inspection. In due course the provider intended to open another designated centre nearby and this would also fall under the remit of the person in charge. The person in charge was supported in their role by a community services manager. The person in charge met the requirements of regulation 14 in relation to relevant qualifications and management experience.

A provider led audit programme was in place to ensure key quality areas of practice were regularly monitored and reviewed. A suite of operational management audits were in place and there were provisions to ensure a six monthly provider led audit and annual report would be completed to meet the regulatory requirements of Regulation 23.

Effective staffing arrangements ensured that the number and skill-mix of staff working in the centre met the assessed needs of residents during the day. One waking night staff was assigned to the centre. This ensured residents could receive supports at night time should they require assistance. A planned and actual roster was in place which identified staff on duty both day and night. Staff observed during the inspection demonstrated caring engagements with residents, respecting residents' personal communication repertoires.

At the time of inspection the provider was filling one whole-time equivalent vacancy with agency workers. To ensure continuity of care and support for residents, the provider ensured the same agency staff worked in the centre each week to address the whole-time equivalent shortage. The inspector was informed that the centre would achieve full staffing resources as further de-congregation of the campus progressed.

The inspector did not review Schedule 2 files for staff on this inspection. They did request provision of evidence that all staff working in the centre were appropriately vetted. This was evidenced by way of up-to-date Garda Vetting for all staff.

A sample of incidents reports were reviewed and it was identified that all notifiable incidents had been submitted to the Chief Inspector as required by the regulations.

The provider had effective governance arrangements in place to ensure the statement of purpose for the centre was regularly reviewed and met the requirements of Schedule 1 of the regulations.

Regulation 14: Persons in charge

The provider had appointed a full-time person in charge. They met the requirements of regulation 14 and sub-regulations in relation to management experience and qualifications.

Judgment: Compliant

Regulation 15: Staffing

At the time of inspection staffing resources met the whole-time equivalent ratios set out in the statement of purpose. The provider had plans in place to ensure staffing resources in the centre would be filled by full-time workers.

The provider had ensured all staff working in the designated centre had been appropriately vetted.

Judgment: Compliant

Regulation 23: Governance and management

The provider had systems in place to ensure an annual report would be completed and six monthly provider led audits would occur. An operational auditing system was in place which ensured quality of care was consistently reviewed. Clear reporting

and accountability systems were in place.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose met the requirements of Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

There was a system in place to ensure notifiable events were submitted to the Chief Inspector as per the regulations. All required notifications had been submitted.

Judgment: Compliant

Quality and safety

It was demonstrated on this inspection that residents were provided a good quality service where residents' communication, health-care and social care needs were managed and supported to a good level in a person centred, caring way. Some improvement was required in relation to risk management, procedures for the management of emergency medication for seizures, restraint management oversight and fire safety and evacuation procedures.

Overall, it was clearly demonstrated residents were experiencing improved quality of life outcomes in their daily lives since moving from Saint Patrick's Centre congregated setting. The provider had ensured residents were provided with a comfortable home which could support their social care needs and integration within their local and wider community.

Throughout the premises was maintained to a high standard. Each resident had their own bedroom which was tastefully decorated with personal effects. Toilet and bathing facilities were also to a good standard with evidence of assistance aids and appliances available for residents. It was also noted each resident had a double bed with comfortable bedding and pillows. Staff had ensured the centre was decorated for Christmas, with a Christmas tree, Christmas lights and decorations throughout, making the centre look homely and inviting.

The provider had ensured residents received a comprehensive assessment of needs through an allied health professional framework. Residents' personal plans were comprehensive and demonstrated residents assessed needs were reviewed regularly with updated recommendations provided following each review. This ensured residents best possible physical and mental health outcomes were being achieved and continuously monitored to a good standard in this centre. Residents were also receiving improved quality nutritional provision in line with their assessed dietary requirements and in consistencies that met their needs.

Each resident had received a comprehensive person centred planning meeting, referred to as a 'visioning meeting' where meaningful goals were identified for them. While this comprehensive work had been carried out, an action plan with review dates and persons responsible for supporting the resident to achieve these goals had not yet been put in place.

Residents living in this centre required positive behaviour supports to manage some personal risks related to self-injurious behaviour. The provider had ensured residents with these needs were supported by appropriately skilled and qualified allied health professionals. A low arousal living environment was required to support residents in this regard and it was demonstrated that residents' new home could provide such an environment. Some small improvement was required. Not all staff had received training in the management of behaviours that challenge which was necessary to ensure quality supports were implemented by staff supporting residents living in this centre on a daily basis.

While it was demonstrated that overall a low level of restrictive practices were implemented in this designated centre, a restraint register was not in place. Some restrictive practices implemented at meal times had not been reviewed since residents had moved to their new home. It was demonstrated that these were required to ensure residents' health and nutritional needs were being met in line with allied health recommendations. However, review was required to ensure this was done in the least restrictive way.

The provider had ensured appropriate fire safety precautions and containment measures were in this centre and to meet the regulations and fire safety standards for community residential dwellings. Fire safety equipment was serviced as required and a functioning fire alarm was present in the centre. However, it was not demonstrated that the fire alarm system had a specific control system in place to alert staff as to the location of fire or smoke in the centre should the fire alarm be activated. This provider was required to review this to ensure a system of the appropriate standard was in place.

It was noted that the provider had made arrangements for an evacuation aid to be located in each residents' bedroom at night time. Fire and smoke containment measures in this centre were robust and all exit points from the premises were wheelchair accessible. Residents had participated in a fire evacuation drill since transitioning to the centre in October 2018. This demonstrated that timely evacuation was possible during the day time with three staff. However, it was not demonstrated that the provider and person in charge had assessed if all residents

could be evacuated, in a timely way, at night time with the allocated resources of one staff member. The provider and person in charge was required to review this arrangement and assess if any improvements were required thereafter.

A risk management policy that met the requirements of the regulations was in place. As part of the provider's overall risk management systems an electronic incident recording system had been implemented across the service and was in place in the designated centre. This system was being utilised and found to effectively record incidents should they occur in the centre. A risk register was in place which set out detailed and informative control measures in place to mitigate and manage each risk or hazard identified. Some improvement was required to ensure it captured all risks presenting in the centre, for example, risk control measures for the management of some sharps, safe use of Christmas lights and medications requiring specific health-care monitoring.

Risk control measures for the emergency management of seizures associated with epilepsy were not consistently implemented. Residents' personal plans identified that their medication for the emergency response to seizures, was to accompany them on trips and activities outside of the centre at all times. However, on the day of inspection it was noted that two residents had attended activities away from the centre but staff had not brought their emergency medication with them. This was brought to the attention of the person in charge. It was noted they had not required the use of the emergency medication during their time away from the centre.

The provider had ensured a comprehensive medication management policy was in place to direct best practice. Medications were stored securely. Medication administration documentation was clearly documented. Only staff trained in safe administration of medication could administer medications in the designated centre.

In the main appropriate infection control procedures were in place and were appropriate given the purpose and function of the designated centre. Some improvements were required for the appropriate and safe disposal of sharps.

Each resident had received a comprehensive annual health check and review by their General Practitioner. Residents' health-care needs were also assessed and reviewed by a number of allied health professionals. Recommendations were made available in their personal plans. Residents were also supported to avail of public health care screening initiatives. Some improvement was required to ensure male specific health checks were up-to-date.

Regulation 17: Premises

The provider had ensured residents were provided with a spacious, modern, comfortable home, which could meet their assessed needs. The premises was well maintained throughout. Residents were afforded comfortable bedrooms and accessible bathing and toilet facilities. The centre was located in a small town which could support residents' integration into their local community.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents were afforded nutritious, home cooked meals prepared and modified to consistencies in line with their assessed needs. Some residents required specific supervision supports during meal times and it was observed their new home could afford them a better quality mealtime to meet their overall assessed nutritional needs. Food prepared and served during the course of the inspection was apetising and home made. Residents appeared to thoroughly enjoy their meals.

Judgment: Compliant

Regulation 26: Risk management procedures

Some improvement was required to ensure the risk register captured all risks and hazards presenting in the designated centre, some examples are detailed in the body of the report.

Residents' personal plans indicated residents' emergency medication for the management of seizures should be brought with them on any activity or trip outside of the designated centre. However, on the day of inspection this medication did not accompany two residents while they went on an activity outside of the centre. Risk management systems for the management of seizures were not implemented effectively.

Judgment: Not compliant

Regulation 27: Protection against infection

Some improvements were required for the appropriate and safe disposal of sharps.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Robust and effective fire and smoke containment measures were present throughout the designated centre. Staff had received fire safety training. A smoke

alarm was also present and emergency lighting. A day time evacuation drill had occurred since residents had transitioned to the centre demonstrating effective procedures and resources were in place.

However, the person in charge and provider had not assessed if staffing resources allocated to the centre at night time could evacuated residents in a timely manner.

A fire safety system to inform staff as to the location of fire or smoke, was not present in the centre.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Safe and appropriate medication management systems were in place in this designated centre. Only staff trained in safe administration of medication administered medication in this centre.

Some residents required specific health-care checks as part of the overall management and supervision of specific medication they received. It was noted that they were supported to receive these health checks as required on a consistent basis.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident had received a comprehensive assessment of need through an allied health professional framework. Each resident had also received a personal goal planning meeting, referred to as a visioning meeting. While goals were set following each meeting an associated action plan, with time-lines and persons responsible had not been developed.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had received a comprehensive health-care check by a number of allied health professionals. It was also demonstrated that timely review of any changes in their health occurred. Residents had also received an annual health check and there was evidence of health-care screening afforded to them. Some improvement was

required to ensure male specific health checks were up-to-date in line with the outcomes of the annual health check assessment.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Some residents required specific behaviour supports for the management of self-injurious behaviours. Residents were reviewed and supported by allied health professionals in this regard. Behaviour support planning in place was up-to-date.

Not all staff had received training in the response and management of behaviours that challenge.

Some improvement was required in relation to the ongoing review and assessment of restrictive practices. For example, there was no restrictive practice register in place. Some restrictive practices at mealtimes required review to ensure they were the least restrictive but, also in line with allied health professionals recommendations in relation to mealtimes and prevention of health-care risks.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant

Compliance Plan for Ardeevin OSV-0005777

Inspection ID: MON-0024990

Date of inspection: 06/12/2018

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 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The risk register for the designated centre was reviewed and updated with the following risk assessments:
• Management of sharps/razers
• The safe use of Christmas lights
• Medication for the use of emergency medication for Epilepsy

The PIC also developed 2 Standard Operating Procedures to accompany the risk assessments:
• SOP for the management of sharps/razers
• SOP around the support of people using emergency medication for Epilepsy

The PIC has ensured that all employees have read and understood the risk assessments and Standard Operating Procedures using a signature sheet for each. The risk register and Standard Operating Procedures will be reviewed every 3 months or earlier as required.

There is a Medication Policy in place within St. Patrick's Centre (Kilkenny). This policy gives clear guidelines on how to manage emergency medication for Epilepsy. There is clear guidance around Epilepsy for each person supported who has a diagnosis for Epilepsy. Each person has an epilepsy care plan, emergency medication protocol (stored in their personal file and in their medication pouch), seizure incident reports and an annual seizure chart.

Immediately after the inspection took place the PIC ensured that all employees have read and signed the Medication Policy and are aware of the guidelines for managing emergency medication for Epilepsy.
At the team meeting on the 25/01/2019 the Medication Policy, the updated and new risk assessments, the new Standard Operating Procedures and the individual epilepsy documentation for the people supported will be discussed between the PIC and employees

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
An Infection Control Policy is in place within St. Patrick's Centre (Kilkenny). The appropriate and safe disposal of sharps is now ensured in the designated centre. The PIC purchased a sharps box. A risk assessment and Standard Operating Procedure are completed to ensure the safe disposal of sharps.

As support for employees the PIC will ensure that the Infection Control Policy, the risk assessment and Standard Operating Procedure will also be part of the Team Meeting Agenda on the 25/01/2019.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The PIC assessed the staffing resources for a night time evacuation in the designated centre. A night time fire drill was completed after the inspection at 6:30am on 07/12/2018.
The report of this fire drill was sent to the Inspector on 13.12.2018. In response to the learning from the fire drill one PEEP of a person supported was amended and updated.

The PIC has contacted ACE Fire Protection who carry out the fire training in St. Patrick's Centre (Kilkenny). The PIC is awaiting a date from ACE to visit the designated centre to review the fire evacuation plans.

Oaklee Housing who are the approved housing body for the designated centre completed the installation of a controller to the fire alarm on 17/12/2018. The controller will indicate the location of a fire or smoke in the house. The LDI certification from the fire safety engineer was forwarded to the Inspector on 02/01/2019.

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:
Within the Visioning Process the Community Transition Coordinator is leading a process between the PIC, keyworker and family of each person to develop socially valued roles with the person supported. Out of these developed roles, achievable goals and actions have been developed for each person supported in the designated centre.
The documentation being used within the Visioning Process evidence the progress of the people supported achieving their social roles and goals. Action plans and responsibilities of keyworkers to evidence the progress is documented and can be found in Section 10 of the daily working file of each person supported.

The PIC is reviewing the action plans on a monthly basis and is supporting the keyworker to achieve the goals and actions with the person supported through 6 weekly Quality Conversations.

They keyworker of each person supported is updating the team of the designated centre

at the monthly team meetings about the progress of goals and actions within the visioning process.

Within the Person Supported Pathway to MDT each person has a monthly in house review meeting, where current issues and needs are discussed and agreed. The keyworker, PIC and CSM attend an annual MDT review meeting.

All these meetings ensure that the supported person's personal plan is not only the subject of a review by the keyworker and PIC, but also by appropriate health care professionals to reflect changes in need and circumstances.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
A new, updated annual medical form for the annual health check/review with the General Practitioner is available now for the people supported in the designated centre. This form includes also male health checks like PSA blood test and prostate check.

It is ensured within St. Patrick's Centre (Kilkenny), that all male and female supported can avail of their health screenings. Documentation of the health screenings for each person supported can be followed through the annual MDT review meeting and the annual medical form.

An internal working group in St. Patrick's Centre (Kilkenny) met on the 15.01.2019 to discuss the standardised documentation for health screenings.
Following actions will be completed by the working group:

• A Health Screening data base is in the process of being developed to ensure the monitoring of health screening data for all people supported within St. Patrick's Centre (Kilkenny). This data base is held centrally in the Medication Management Department and administered by the Project Officer.

• The data base will cover Breast check, Cervical check, Bowel screening and Diabetic Retina screening and will be live and can be updated at any time.

• The Intimate Care Plan for each person supported has included guidelines for employees regarding the observation of changes under each health screening section.
• A Standard Operating Procedure was developed to guide employees regarding what actions to take if any changes or abnormalities are observed.

• A library of documentation (e.g. easy read booklets, video clips, audio clips,…) to support staff in communicating health screenings to the people supported.

The development of these documents and the data base will help employees in providing the best possible support.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive

behavioural support:
The PIC and employee team reviewed the restrictive practices in the designated centre. A restrictive practice register is now in place in the designated centre. All restrictive practices are reviewed on a 3monthly basis.

The format of the register was improved and includes now the following sections:
• Person supported Unique Identifier Number
• Restrictive Practice
• Date of Implementation
• Date of Restrictive Practice Assessment
• Professionals recommendations
• The rationale for the restrictive practice
• What control measures are in place
• Date of Review of Restrictive Practice
• Restoration of Rights plan in place (including review date)

As a result of the review of restrictive practices in the designated centre, the restrictive practices for two people supported using feeding chairs at mealtime were reviewed. A restoration of rights plan is in place for both people. Employees are supporting the people during mealtime to use alternative chairs.
The PIC and employee team developed guidelines regarding the support of alternative mealtime chairs for each person, which were read and signed by all employees in the designated centre.
The PIC is guiding the employees through the 6 weekly Quality Conversations and team meetings within the support guidelines at mealtime for the two people supported.

At the annual MDT review meeting for both people supported on 07/01/2019 the review of the restriction and the restoration of rights were discussed. The MDT team is supporting the guidelines around the use of alternative mealtime chair for both people and gave assurance and guidance to the employee team.
The progress will be monitored through monthly review meetings, as per MDT Pathway.

As not all employees have received training in the response and management of behaviours that challenge, the PIC will ensure to book employees in for Studio 3 training in February and March 2019, as soon as the new training dates are available.

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 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	18/01/2019
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	07/12/2018
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	17/12/2018
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	07/12/2018

Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Substantially Compliant	Yellow	18/01/2019
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	15/01/2019
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.	Substantially Compliant	Yellow	31/03/2019
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	07/01/2019