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:	Stewarts Care Adult Services Designated Centre 8
Name of provider:	Stewarts Care Limited
Address of centre:	Dublin 20
Type of inspection:	Unannounced
Date of inspection:	07 January 2019
Centre ID:	OSV-0005830
Fieldwork ID:	MON-0026467

About the designated centre

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

This centre aims to promote, empower and support people with intellectual disabilities to lead meaningful and fulfilling lives. This centre aims to provide long term residential care to no more than four men and women with high support needs. The centre comprises a two storey house which is divided into three individual apartments, and one self contained apartment. The centre is staffed by a team of nurses, care assistants and day service staff and has a full time person in charge. Residents living in this centre have access to clinical services such as psychiatry, psychology, occupational therapy, speech and language therapy, social work and physiotherapy.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
07 January 2019	10:00hrs to 18:10hrs	Louise Renwick	Lead
07 January 2019	10:00hrs to 18:10hrs	Amy McGrath	Support

Views of people who use the service

Inspectors met all four residents living in the designated centre, and spoke specifically with two residents. Inspectors met some family members during the inspection and spoke with them and with staff.

Of the residents and families spoken with, inspectors were informed that residents were content living in the centre, liked their home and the supports being given. Some residents showed inspectors around their apartments and were happy with their homes and had decorated them to their own tastes. Residents were positive about their experiences in the centre, the staff team and how they spent their days.

Inspectors observed residents being treated with respect, in a warm and friendly manner by staff members. Interactions were seen to be positive.

Capacity and capability

The provider had submitted a plan to the Office of the Chief Inspector to reconfigure six large designated centres based on the campus, into 19 smaller designated centres to improve the oversight and management of the care and support being delivered to residents. This proposed designated centre consisted of four apartments for four residents, and was previously a unit under a larger designated centre called "Stewarts Adults Services Palmerstown Designated Centre 1" which had catered for 21 residents overall under the responsibility of one person in charge. The provider had applied to register this centre as a stand alone centre, and the findings of this inspection were to inform the decision on registration. Inspectors reviewed the application, and followed up on previous areas of non-compliance relevant to this centre from the last inspection report dated 04 April 2018. Inspectors also reviewed a written improvement plan submitted by the provider in relation to this centre to support their application to register.

Inspectors found that while local improvements were still required to ensure effective oversight and monitoring of the care and support being delivered in the centre, the provider had taken appropriate action and strengthened the governance and management structure and systems overall. Inspectors found that the provider had demonstrated that they had improved their capacity and capability to operate this centre in a manner that would benefit residents. Inspectors found that the written improvement plan for the centre clearly demonstrated how the provider would meet the regulations over the next three years and improve the lived experience of the four residents living in the centre. The improvement plan submitted gave clear accountability and responsibility to key managers and staff to

ensure actions were carried out, and the improvement plan was reviewed on a monthly basis through formal management meetings. At the time of the inspection these new systems were only beginning to be implemented and the local monitoring and oversight arrangements still required improvements. For example, while some audits had been carried out and acted upon in areas such as health and safety, other areas had not yet been reviewed and improved upon such as healthcare documentation.

Inspectors found that there was a clear management structure in place which had been improved further since the last inspection of this unit in April 2018. Reporting procedures were clear; the person in charge was a clinical nurse manager who reported to a programme manager; the programme manager reported to the the Director of Care of Residents and the Director of Nursing (who also held the role of assistant Director of Care). Staff were aware of who was in charge and the lines of reporting in place for the centre.

There were clear systems in place to ensure the executive management team and the provider had oversight and were informed of the quality and safety of the care and support being delivered in this centre. For example, monthly care management team meetings were now occurring. The purpose of this meeting was to discuss the care and support being delivered in this centre based on a comprehensive report brought by the relevant programme manager. Following this, the director of care (residents) would present the information to the executive management team.

Inspectors found improvement in relation to risk management which resulted in a better understanding and management of risk. The provider had implemented a new risk management policy following the appointment of a Head of Risk and quality, and senior managers and people in charge had received training in risk management. This training was scheduled to be delivered to all staff during the year.

A new sub-committee of the board was put in place in January 2019 for Quality, Safety, Risk and Policy, and this sub-committee would meet monthly. A number of personnel had been identified to report into this sub-committee on areas such as residential services, fire safety, risk, policy development and review. This sub-committee would further inform the provider of any matters of concern in each centre and ensure that quick action could be taken to improve the quality of care being delivered to residents.

The provider had recently appointed a new programme manager to hold responsibility of this centre and to support the person in charge. This increased the number of programme managers working in the campus centres to three. While inspectors found that new management processes had been set up by the provider to support local management in fulfilling their responsibilities, these were at their infancy at the time of inspection. The person in charge and programme manager had plans to formalise their oversight and communication going forward now that the management structure had been strengthened.

The provider had arranged for an unannounced visit to the centre on their behalf

which was completed by an external person on 11 April 2018. This audit identified that actions were needed in relation to the quality of the care planning documentation and the completion of incident records. While the records of incidents had improved in their content, care planning documentation was still an issue on the day of the inspection. The provider had identified in its written improvement plan that all identified health needs would have a care plan in place by April 2019. However, given the provider's own audits had been identifying this as an issue since April 2018 swifter action was required.

Inspectors found that there was a system in place to record all adverse events and to monitor for patterns or trends. Inspectors found there to be a low number of adverse events in the centre over the period of October 2018 to the date of the inspection. Inspectors found that the oversight of behavioural incidents had improved since the previous inspection in April 2018. Incidents of this nature were reviewed by the person in charge along with a member of the clinical team, usually the clinical nurse specialist in behaviour.

The provider had employed a team of nurses and healthcare assistants to work in the centre. The staffing levels had been recently assessed in line with residents' needs. At the time of inspection, there were a number of vacancies and these were being covered by agency staffing. The provider had begun a recruitment process with plans to fill all vacancies as soon as possible. Inspectors discussed with the management team the skill mix of the staff, and were informed that two staff members had been sponsored and supported to begin a qualification in social care. Through the recruitment process, the provider was also seeking to hire staff with this background. This would enhance the knowledge of the team and improve the skill mix in place. Inspectors spoke with family members and reviewed records and found that some residents displayed their discontent at being supported by unfamiliar staff as evidenced through the incident review records. The provider understood the need to provide a stable and consistent staff team, and was actively working at providing one.

On review of training records, inspectors found that staff were provided with a suite of mandatory training, with oversight in place to ensure any training needs were identified. On the day of inspection some gaps in training were identified.

The provider had appointed a full time person in charge to manage the centre. The person in charge was a registered nurse, and had worked in the role of clinical nurse manager in this centre since April 2017. The person in charge had been supported to achieve a qualification in management and was found to be suitably qualified to hold the role of person in charge. However, the provider had not demonstrated through the application documentation, that the person in charge had three years experience in a supervisory role, as required by the regulations.

The provider had ensured a written statement of purpose was in place that was in line with Schedule 1 of the regulations. Inspectors found that it was a fair reflection of the services and facilities available in the centre.

Overall, inspectors found that the provider had improved their capacity and

capability to govern and operate this centre in a manner that would benefit residents and enhance their experiences. At the time of the inspection these improvements were only beginning to emerge and positively impact on the quality of the service being delivered. The provider had demonstrated through their improvement plan that they had clear and timebound actions outlined to address these deficits and bring about further improvements overall.

Regulation 14: Persons in charge

While the provider had appointed a full time person in charge in the designated centre, they had not demonstrated through the application documentation, that the person in charge had three years experience in a supervisory role.

Judgment: Substantially compliant

Regulation 15: Staffing

Inspectors found that the person in charge was not ensuring the planned and actual roster were well maintained. The roster did not accurately reflect the staffing on the day of inspection.

There were a number of vacancies at the time of inspection, and the arrangements in place were not effective in ensuring continuity of care for residents. For example, agency staff were booked to work shifts with little notice, and on the day of the inspection there were three shifts without nursing cover arranged for the coming week.

Judgment: Not compliant

Regulation 16: Training and staff development

Training records showed that not all staff were up to date with their training. For example, three staff required training in manual handling and four staff required training in hand hygiene.

Judgment: Substantially compliant

Regulation 23: Governance and management

While the provider had strengthened the governance and management structures and systems in the designated centre, these were at their infancy and local oversight and monitoring of the care and support delivered to residents still required improvements.

The provider had plans to complete an annual review of the designated centre in March 2019. There had been unannounced visits in the designated centre in January 2018 and April 2018. The provider had not ensured an unannounced visit was completed six months later in October 2018. Actions arising from previous unannounced visits had not all been completed. For example, the visit in April 2018 highlighted the need for all health needs to have corresponding care plans.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

A written statement of purpose was maintained, which was an accurate reflection of the facilities and services available in the centre.

Judgment: Compliant

Quality and safety

While the provider had built on their capacity and capability to govern, oversee and operate the designated centre, this was not yet fully resulting in good quality and safe care and support for residents. Inspectors found that residents were afforded a safe and comfortable place to live and had access to meaningful activities and community facilities. While areas in need of improvement were identified on this inspection, the provider had already identified these and had submitted a written improvement plan to the Office of the Chief inspector prior to the inspection. Inspectors found that governance and management had improved at a senior level, and this was beginning to improve the oversight in the designated centre and bring about positive changes for residents living there.

Inspectors found that residents were each afforded a single occupancy apartment. Residents appeared content in their homes, had access to activities and facilities

outside of the centre and were engaging in daily activities in line with their preferences and wishes. Safeguarding measures were in place to protect residents and residents had access to a medical practitioner along with a wider multidisciplinary team to oversee their care. Some families felt that their relatives were comfortable living in the centre, and enjoyed returning back to the centre after home visits.

Some residents required support in order to promote positive behaviour due to their risk of self injurious behaviour. Inspectors found that there was a multidisciplinary team approach to supporting residents in this regard. Each resident had written behaviour support guidelines or plans in place which were regularly reviewed by a relevant professional. The content of these plans and guidelines were known by staff. Restrictive interventions were recorded on a register indicating how long they were used and why and this was reviewed regularly. Inspectors found that some chemical interventions had been reviewed and removed due to no longer being required. Inspectors found that there was good oversight of the use of restrictive interventions, and the staff team were aiming to reduce restrictions as much as possible.

Inspectors found that residents appeared content and safe in their home. Each of the four residents lived alone with the support of the staff team. Any safeguarding issues or concerns had written plans in place and were overseen by the person in charge, staff team and had input from the multidisciplinary team also. Almost all staff had received training in safeguarding vulnerable adults.

Inspectors visited each of the four apartments and met residents. While some apartments were nicely decorated to individual's taste and kept in a good state of repair, others required attention. One resident's bathroom was in need of immediate repair. There was also no hand soap available in the bathroom, and no paper waste disposal. Given that some residents required a lot of encouragement to engage in regular personal care, the bathroom was in need of attention to ensure it was a pleasant environment.

One apartment had been furnished in line with resident's needs as assessed, however general and routine cleaning required improvement. At the time of inspection laundry facilities were not available in the centre. A central laundry was available to residents on the campus, but some families did not avail of this. The washing machine was not working and had been broken for a number of weeks. Inspectors were informed by senior management that a new washing machine had been ordered.

Residents had access to a General Practitoner (GP) and a wider clinical team. Residents had yearly multidisciplinary team meetings and health assessments completed to guide the care in relation to their health for the year ahead. However, inspectors found that improvements were required overall to the monitoring of healthcare needs and updating of records and information. For example, not all identified needs had a corresponding care plan in place. Inspectors also found that there was a disconnect between what was recorded in the prescription records for some as required medicines, and what was outlined in care plans and protocol. The

provider had self-identified these issues in their improvement plan, and had agreed this would be addressed by April 2019.

Inspectors found that residents' right to refuse medicine or treatment was respected by staff, which was a positive thing. However, records were not well maintained. For example, if medicine was refused it was not always documented on their file. Inspectors observed staff engaging positively with residents and trying to support residents in different ways throughout the day regarding their medicine, yet respecting their wishes to refuse. Improvements had been made prior to this inspection in relation to the procedure for accessing medical practitioners, and communicating key information through the development of a new assessment protocol.

Some residents required support in relation to their dietary requirements and the management of weight. Inspectors found that food and fluid records had improved since previous inspections in the frequency and quality of the information they recorded. However, they were not always monitored and linked back to the relevant care plan to ensure residents were eating foods as advised by members of the clinical team. For example, a high iron diet. That being said, residents' right to choose what they ate was respected.

Residents' social and personal needs were in need of an up-to-date assessment, as were plans which outlined their supports and progress. Residents living in this centre were able to demonstrate their choices and wishes in relation to their lives such as refusing medicine and certain supports. However, there was an absence of a comprehensive assessment of residents' social and personal needs to explore what additional supports or skills teaching may be required to ensure their choices were well informed and supported. This was something the senior management team hoped to improve upon by enhancing the skill mix of the staff team. Residents were seen to be engaging in activities of their choice and had good access to meaningful activities. Some residents told inspectors that they were happy with how they spent their day, and told the inspector about things that they enjoyed doing.

Overall, inspectors found areas still in need of address to further enhance the quality of life of residents living in this centre. However, the provider's improvement plan clearly identified and outlined how these would be addressed going forward, and the provider had demonstrated the capacity and capability to bring about these improvements.

Regulation 13: General welfare and development

Residents had access to activities that were meaningful to them.

Residents had access to community facilities and amenities.

Residents were supported to maintain personal relationships with their families.

Judgment: Compliant

Regulation 17: Premises

Some improvements were required to the bathrooms of one apartment which was not in a good state of repair.

Some aspects of Schedule 6 required improvement, such as disposal of general waste in the bathroom, and facilities for residents to launder their own clothes.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had ensured a fire alarm and detection system was in place in the centre, that fire exits were unobstructed and fire fighting equipment was in place. Emergency lighting was in place and fire exits were identifiable.

Training records showed that a high number of staff working in the centre had not completed a fire drill in the location and three staff required training in fire safety. Inspectors were informed after the inspection that all remaining staff would take part in a fire drill by 04 February 2019.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Not all identified needs had a clear plan in place outlining the supports required.

Improvements were required to the documentation of residents care and support needs and the monitoring of their implementation.

Behaviour support plans did not clearly include information on chemical restrictive

interventions.

Residents' social and personal needs required an up to date assessment.

Judgment: Not compliant

Regulation 6: Health care

Residents had access to a General Practitioner and a clinical team which consisted of a psychiatrist, psychologists, occupational therapist, physiotherapist, speech and language therapist, clinical nurse specialist in behaviour, social workers, dietitian and sensory services. Residents also had access to dental services, optician services and chiropody services. While these services were available, some residents did not have timely access to a dietitian when required.

Inspectors found that a stronger system of meetings were in place for members of the clinical team to come together once a year, along with the resident and their representatives to discuss their needs. Residents had all had a multidisciplinary meeting in the last 12 months along with a health check assessment by the nursing team. The systems in place to request medical appointments had recently been improved by the provider. As mentioned above, care planning documentation in relation to residents' identified health needs required improvement.

Residents' right to refuse medical treatment or medicine was respected in the designated centre. However, better recording of this was required.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Residents had their own individual apartments and staffing to promote positive experiences. Residents had access to a clinical team and had support from a clinical nurse specialist in behaviour. Staff demonstrated a good understanding of the residents in their care, and their individual needs.

Three staff required training in the management of actual and potential aggression. Ten staff had been given training by the clinical team in positive behaviour support, and there were plans to ensure all staff completed this.

Residents who required them had positive behaviour support plans in place. Staff were aware and knowledgeable on the content of these plans and techniques to support residents in this regard.

Restrictive practices were monitored daily and reviewed regularly by both the person

in charge, and on a three monthly basis by the provider's "restrictive practices committee". There were protocols in place for the use of physical restrictive interventions or medical interventions.

Judgment: Substantially compliant

Regulation 8: Protection

Inspectors found that the person in charge and staff team had a good understanding of their responsibilities to prevent and respond to safeguarding concerns. Where safeguarding concerns had arisen, these had been reported in line with the provider's own policy and the national policy. The provider had a clinical team in place to support residents who may self injure or self harm.

Inspectors found that all but one staff had completed training in safeguarding at the time of the inspection. The provider had planned for an audit to be carried out in January 2019 to assess the knowledge of the staff team in relation to safeguarding. The provider had plans to hold a safeguarding awareness day in March 2019 to promote safeguarding. Any safeguarding plans in place were reviewed monthly by the person in charge to ensure they were effective.

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	Substantially compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Stewarts Care Adult Services Designated Centre 8 OSV-0005830

Inspection ID: MON-0026467

Date of inspection: 07/01/2019

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 14: Persons in charge	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: The person in charge has three years' experience in a supervisory role and documentation to support this has been forwarded with the application. This has been completed.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A recruitment campaign has been successful and has led to the appointment of additional new staff who have been trained and inducted. The remaining vacancies will be filled by the 1/7/19	
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 training records have been audited and dates set to remediate any gaps in core competency training. Training will be completed by the 1/6/19

Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A new compliance plan has been put in place and dates for completion of actions have been meet. This has been verified by internal audit. This was completed on the 1/4/19	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Works will commence on the 29/4/19 to upgrade the unsuitable bathroom. These works will be completed by the 6/5/19	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Staff will have both the training in fire safety and participation in a fire drill. This will be completed by the 1/6/19.	
Regulation 5: Individual assessment	Not Compliant

and personal plan	

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
All identified needs will have a clear plan in place outlining the supports required by the 1/7/19.

Improvements have been made to the documentation of residents care and support needs and the monitoring of their implementation. This will be completed by the 1/7/19.

Behaviour support plans will include information on chemical restrictive interventions. This will be completed by the 1/7/19

Residents' social and personal needs will be assessed using a new comprehensive format by the 1/9/19.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
All residents have been assessed for dietary need where the MUST assessment has indicated there has been access to a dietitian.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The three staff will receive training in the management of actual and potential aggression. This will be completed by the 1/6/19

All identified needs will have a clear plan in place outlining the supports required by the 1/7/19.
Improvements have been made to the documentation of residents care and support needs and the monitoring of their implementation. This will be completed by the 1/7/19

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 14(3)(a)	A person who is appointed as person in charge on or after the day which is 3 years after the day on which these Regulations come into operation shall have a minimum of 3 years' experience in a management or supervisory role in the area of health or social care.	Substantially Compliant	Yellow	29/04/2019
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	01/07/2019
Regulation 15(4)	The person in charge shall ensure that there	Substantially Compliant	Yellow	01/07/2019

	is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.			
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.	Substantially Compliant	Yellow	01/06/2019
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	06/05/2019
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	06/05/2019
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	01/04/2019
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered	Substantially Compliant	Yellow	01/04/2019

	provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.	Substantially Compliant	Yellow	01/04/2019
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health,	Not Compliant	Orange	01/07/2019

	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.			
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	01/07/2019
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Substantially Compliant	Yellow	29/04/2019
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	Substantially Compliant	Yellow	01/06/2019

	techniques.			