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:	Skylark 1
Name of provider:	Brothers of Charity Services Ireland
Address of centre:	Limerick
Type of inspection:	Announced
Date of inspection:	01 & 02 May 2018
Centre ID:	OSV-0004832
Fieldwork ID:	MON-0021563

About the designated centre

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

Skylark 1 comprises of three, two-storey houses on the outskirts of Limerick city. Two of the houses are within a short walking distance of each other. Each house has its own outdoor area and is located near many social and recreational amenities including local shops and services, and transport links. Each resident living in the centre has their own bedroom, some of which are en-suite. The centre provides a residential service to people aged over 35 years old, who have been diagnosed with an intellectual disability. Skylark 1 is open 365 days a year. When residents are attending day services, the centre is not staffed. It is stated in the statement of purpose for the centre that the purpose of Skylark 1 is to provide each resident with a safe, homely environment which promotes independence and quality care based on the individual needs and requirements of each person.

The following information outlines some additional data on this centre.

Current registration end date:	30/11/2018
Number of residents on the date of inspection:	7

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
01 May 2018	12:05hrs to 18:50hrs	Caitriona Twomey	Lead
02 May 2018	08:50hrs to 16:20hrs	Caitriona Twomey	Lead
02 May 2018	09:00hrs to 16:20hrs	Margaret O'Regan	Support

Views of people who use the service

Inspectors spent time with all seven residents living in the centre at the time of the inspection. Many of the residents living in the centre are very independent and demonstrated this to inspectors. Some residents chose to show inspectors around their homes and bedrooms and were visibly happy with their input into how these areas were decorated.

The majority of residents reported that they were happy with who they lived with. One person expressed a wish for a housemate and was reassured by staff that the current situation would be reviewed. All residents appeared at ease in the company of their housemates and the staff supporting them. Residents spoke about, or demonstrated, the things they enjoy doing, both independently and with support from staff.

Seven questionnaires were also completed, six by residents (five with staff support) and one by a staff member on a resident's behalf. The feedback reviewed was very positive. Overall happiness with the centre, meals, and staffing support were rated positively in all questionnaires. The majority of residents were clear on who they would speak to if unhappy. Residents who had made complaints were happy with how these had been addressed. Since the previous inspection, there had been a reduction in the number of residents living in all houses that comprise the centre. Four of the questionnaires stated that residents were happy with the current situation in the centre and did not want anything to change. Any issues noted in the questionnaires were raised with the person in charge during the inspection. This will be further referenced under capacity and capability.

Capacity and capability

Overall inspectors found evidence of good practice in the management and governance of service provision in the centre. However, it was identified that improved oversight was required in a number of areas. Review of documentation in the centre also identified non-compliance with the regulations.

There was evidence of clear reporting structures in the centre. The person in charge had been in this role since July 2014. He was supported in the management of the centre by an area manager who acts as a person participating in management. A regular supervision system was in place and the person in charge spent time in each house every week facilitating supervision of staff and the service provided, and opportunities to meet with residents. In addition a monthly meeting was held with

residents, the person in charge and area manager.

The staff team were found to be well-trained and knowledgeable about residents' needs and preferences. There was evidence of good oversight of training needs in the centre, with all staff up-to-date in mandatory training. Based on residents' needs other appropriate training had been identified and was being rolled out to all staff. There were a number of audits completed in the centre demonstrating a commitment to ongoing monitoring and service improvement. While there was evidence of appropriate and timely responses to adverse incidents in the centre, improvement was required regarding the notification of these events to HIQA, as is required by the regulations. Inspectors identified areas where improved oversight was required. These included risk management, fire precautions, medication management, restrictive practices, the complaints process, written service agreements, and guidance to staff regarding verbal reports made by one resident.

Over the course of the inspection there appeared to be a culture of openness and responsiveness regarding feedback, including complaints, in the centre. Issues reported in the HIQA questionnaires for residents were discussed with the person in charge. In response, he reported that plans were already underway to address some of these issues (as he was already aware of them) and was confident that the others could also be resolved promptly. Following a review of the complaints logs in two houses, it was evident that documentation and oversight of complaints required improvement. The entries in the logs were not always fully completed and it was not always clear what action, if any, was taken as a result of these complaints. This included the escalation of issues to management where appropriate. It was also identified, through a review of daily notes for one resident, that complaints made were not always documented as such.

From a review of the daily notes relating to this resident, it was evident that staff were not clear on whether some verbal reports were behaviours that challenge, complaints or safeguarding issues. As a result of this ambiguity, this information was often recorded in daily notes only and other processes and procedures were not followed as per the organisation's own and national policies.

A sample of written agreements were reviewed by inspectors. These did not meet the requirements of the regulations. It was also identified that many policies had not been reviewed within the required time frame. Inspectors were assured that the service provided was in line with the statement of purpose. However, some minor amendments were required for this document to meet the associated regulation.

Regulation 14: Persons in charge

The person in charge fulfilled this role for this centre only and met the requirements of the regulations.

Judgment: Compliant

Regulation 15: Staffing

The staff team was appropriate in number and skill mix to meet the assessed needs of residents. There was a consistent staff team in place in each house that comprised the centre. Inspectors did not review the information and documents, specified in Schedule 2 of the regulations, in relation to staff on this occasion.

Judgment: Compliant

Regulation 16: Training and staff development

Inspectors reviewed the training records of 12 staff working in the centre. Mandatory training was up-to-date for all staff. In addition the organisation had started to roll out specific training which reflected the residents' changing needs. A staff supervision system had also been introduced for all staff.

Judgment: Compliant

Regulation 23: Governance and management

The provider met the requirements regarding six-monthly unannounced visits to the centre and the completion of an annual review. However, areas for improved oversight were identified to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The fees to be charged to residents were not clear in the sample of written agreements reviewed by inspectors. It was also identified that these agreements had been signed by staff members on residents' behalf.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose did not include all of the information outlined in Schedule 1 of the regulations including information set out in the centre's certificate of registration and arrangements for the supervision of therapeutic techniques used in the centre. It was also identified that some of the information included was inaccurate.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A serious injury to a resident requiring hospital treatment had not been notified to HIQA, as is required by the regulations. It was also identified that the use of restrictive practices and some safeguarding concerns had not been notified.

Judgment: Not compliant

Regulation 34: Complaints procedure

Although a complaints procedure was in place, and each house had its own complaints log, improvement was required regarding the documentation and oversight of complaints in the centre.

Judgment: Not compliant

Regulation 4: Written policies and procedures

Almost 50% of the policies and procedures outlined in Schedule 5 of the regulations had not been reviewed within the required timeframe.

Judgment: Not compliant

Quality and safety

There was evidence that residents received a person-centred service and experienced a good quality of life in the centre. Improvement was required to ensure that the provider was accurately identifying and assessing all risks in the centre and to meet the regulations regarding medicines and fire precautions.

It was evident that the service provided to each resident was tailored to their needs, interests and preferences. The service had adapted the support provided to one resident following a change in his health and support needs. This individualised, home-based service enabled this resident to maintain the important relationships in his life and supported engagement in activities he previously enjoyed, while also incorporating new recreation and social opportunities. Other residents living in the centre were also involved in a wide variety of activities and learning opportunities. Residents both spoke with and demonstrated to inspectors their many interests, roles, skills and talents. It was apparent that residents were aware of and interested in accessing the Internet; however this was only available to staff in the centre. All residents regularly spent time in the local community and were supported to maintain strong family relationships.

Inspectors reviewed a sample of documentation relating to residents, including assessments and personal plans. There was evidence of regular review of these plans by a team including multidisciplinary professionals. This ensured that plans reflected the residents' current needs and that staff were provided with clear guidance on how to provide appropriate support. The service had recently begun to roll out a new template to support the assessment of residents' needs. These comprehensive assessments included various multidisciplinary recommendations; however, they did not specify who was responsible for implementing the recommendations and the timescales involved. Each resident had developed their own goals that they wished to achieve. Through review of residents' personal plans, conversations with residents and staff and minutes of resident meetings, inspectors were assured that resident participation was encouraged and supported in all aspects of service provision in the centre.

All residents in the centre had access to their own choice of General Practitioner (GP). There was evidence that residents accessed public health initiatives, specialists and other allied health professionals in a timely manner, as dictated by their needs. Inspectors identified that documentation in the centre did not reflect all of the residents' assessed healthcare needs.

Overall there was evidence of effective systems in place for the ordering, receipt, prescribing, and administration of medications. There was evidence of good practice regarding the documentation and learning from medication errors. It was identified that improvements were required in the documentation and storage of out-of-date or returned medication. In addition, despite their independence in a number of areas, residents had not been encouraged or assessed regarding their capacity to take responsibility for their own medication.

There was a system to identify hazards and address risks in the centre. A review of risk assessments demonstrated that the risk posed by a number of identified hazards had decreased following implementation of control measures. There was

also evidence of good practice regarding the documentation of accidents & incidents. However, inspectors identified hazards in the centre that had not been identified or risk assessed, such as residents spending time in the centre without staff support, and residents being supported on a one-to-one basis by a lone worker. There was evidence to suggest that these situations could pose a potential risk to residents. It was also identified that one individual risk assessment did not reflect the resident's current situation or support needs.

Fire precautions in the centre were also reviewed. The provider had submitted to HIQA a two-phased schedule of works regarding fire safety in October 2017. At the time of inspection, works had been completed in two of the houses as per the time line submitted. Contrary to this plan, one of the houses did not yet have emergency lighting or an integrated fire alarm system installed. Inspectors were advised that this was scheduled for later in the month. On the day of inspection, there were no fire doors in any house that comprised the centre. Inspectors reviewed the fire folder in one house. Improvement was required regarding documentation. For example, the emergency plan under-reported the fire fighting equipment available in the house, personal emergency evacuation plans had not been reviewed in the last 12 months and a drill record did not document the evacuation time. In addition, there was no record available to confirm that all equipment had been serviced.

There were effective systems in place regarding all identified safeguarding concerns in the centre at the time of inspection. The majority of concerns that had been previously notified to HIQA had been addressed by a number of residents moving within the centre and to other services. It was identified on review of daily notes in one house, that while action had been taken to safeguard residents, that the correct procedures had not been followed in line with national policy.

There were assessments and behaviour support plans in place for residents that required these supports. The person in charge spoke with inspectors regarding two restrictive practices implemented in the centre. There was evidence of regular review of the use of these practices. During the inspection a third restrictive practice was identified. This had not been recognised as such by the person in charge and as a result it had not been applied in line with the organisation's policy.

Regulation 10: Communication

Throughout the inspection, staff were observed interacting with residents in line with their communication needs and preferences. While there was available access to some forms of media, none of the residents had access to the internet while in the centre, despite expressing an interest in same.

Judgment: Substantially compliant

Regulation 13: General welfare and development

The registered provider met the requirements of the regulations. There was strong evidence of the provider adapting how they facilitated access to meaningful activity and relationships in line with residents' changing needs and preferences.

Judgment: Compliant

Regulation 17: Premises

Each house that comprised the centre was clean, warm and decorated in a homely manner. Each house was kept in a good state of repair and was accessible to those living there.

Judgment: Compliant

Regulation 26: Risk management procedures

Inspectors identified a number of hazards in the centre that had not been identified or risk assessed. It was also identified that one individualised risk assessment was not reflective of the current situation.

Judgment: Not compliant

Regulation 28: Fire precautions

There were no arrangements for the containment of fire in the centre. Although installation was planned, one house required an integrated alarm system and emergency lighting. Documentation in the centre regarding fire precautions also required improvement.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Out of date or returned medicines were not segregated from other medicinal

products. Improvement was also required regarding the documentation of returned medications. Residents had not been assessed regarding their capacity to take responsibility for their own medication.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

In a small sample of the assessments reviewed by inspectors it was not specified who was responsible for implementing the recommendations outlined.

Judgment: Substantially compliant

Regulation 6: Health care

Inspectors identified some gaps in healthcare documentation.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

One restrictive procedure implemented in the centre had not been identified as such. As a result it was not applied in line with the organisation's own and national policies.

Judgment: Substantially compliant

Regulation 8: Protection

There were effective systems in place regarding all current safeguarding concerns in the centre. From review of daily notes, it was identified that staff had not identified a previous safeguarding concern as such and as a result had not followed the organisation's own and national policies.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The registered provider met the requirements of this regulation. There was evidence to support residents' participation in their own interests and the overall service provided. Many of the residents were aware of, and involved in, advocacy groups.

Judgment: 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 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 13: General welfare and development	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	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Skylark 1 OSV-0004832

Inspection ID: MON-0021563

Date of inspection: 01 & 02/05/2018

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 23: Governance and management</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Registered provider has a system for carrying out 6 month unannounced inspection process of the designated centre which includes meeting with a number of residents from the center, meeting with staff, meeting with the Person in Charge and a review of a sample of files.
A report is prepared following the unannounced visit on the safety and quality of care and a copy of same is maintained by the Person in Charge and made available on request to the inspector.
Data generated from internal reviews, risk assessment, accidents and incidents and simulated evacuations will be standing order agenda items on the management team's monthly meetings with a view to ensuring adequate response to this information.
Escalation of risks within the management structure will take place as per Risk Management procedure if mitigations to address the risk are inadequate.</td></tr>
<tr><td>Regulation 24: Admissions and contract for the provision of services</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
The individual service agreement currently sets out the contribution paid by each resident.
The individual service agreement template will be updated to reference the "Policy on the handling of the Personal Assets of Adult Individuals who use the Services" Policy. This policy sets out in detail what is provided by the services and what the individuals pay for using their personal funds.
The Person in Charge will then meet with each individual in the designated centre to review the individual service agreement and their signature will be requested where they have the capacity to understand the agreement.</td></tr>
</table>

- Where a resident does not understand the agreement the Person in Charge will document his efforts to explain same to the individual.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose

- The Statement of Purpose and function has been updated on 15/05/18 to include all of the information outlined in Schedule 1 of the regulations.
- Proof of qualification and registration of outside therapists will be sourced and placed on file.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

- All injuries to a resident will be reported to HIQA in line with regulation 31.
- One restrictive practice which was not documented as a restrictive practice has now been written up.
- PIC will notify the use of all restrictive practices in quarterly returns commencing in Q2 2018.
- A risk assessment will be put in place for 1 resident in relation to a history of inaccurate reporting. The risk assessment will be developed in consultation with relevant members of MDT including the designated officer. This risk assessment will provide guidance to staff regarding verbal reports from resident and provide guidance to PIC and PPIM in relation to notifying HIQA.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

- The local operational complaints procedure will be reviewed with all staff in the designated centre to ensure that they understand the procedure and their role in the implementation of same including receiving, recording, responding to and escalating issues raised as appropriate.
- Daily notes will be reviewed by the Person In Charge to ensure that any issues of complaint are documented appropriately.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

- Currently 2 of the policies and procedures in Schedule 5 remain outstanding for review.
- These are currently being reviewed by the National Policy Group and will be updated by 31st December 2018.

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:

- WIFI access for residents is being addressed nationally and a Policy will be developed that will deal with the legal issues that have been identified in rolling out this access. This will be address by 31/12/2019.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

- Risk Assessments have been put in place on 06/05/2018 for people who use the services in respect of being left without staff support when staff are engaged in the specific care of a peer.
- Risks identified during the inspection have been assessed including lone working staff working with an individual who has a history of inaccurate reporting.
- A Risk Assessment has been closed on 06/06/2018 re sleeping pattern of a person who uses the service who had difficulty in sleeping for a period in 2017 and whose sleeping pattern had improved substantially. 31

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

- Integrated alarm system and emergency lighting are now in place in all houses in the designated centre.
- As outlined in the letter from the provider to HIQA on the 27/10/2017 resources in respect of funding phase 2 fire upgrade works have not been made available. However we continue to seek the appropriate resources required.
- All records in the fire register are now current and reviewed monthly by PIC.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

- All persons who avail of the services have been given information regarding the self- administration of medication. This has been explained to them by PIC and staff. 6 of the 7 requested that staff continue to have responsibility for the administration. Appropriate documentation signed by people who use the service has been put in place. One person was confused about the issue and further explanation will be given as he requested more time for consideration.
- PIC has reviewed the requirement to record when medication is returned to the pharmacy verbally with staff. This will be revisited and minuted formally at the next staff meeting in August 2018.

• Return to pharmacy medication storage box is now in place in line with revised Community Medication Procedure.	
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: • PIC, Area Manager or Senior Instructor to ensure that the person to follow up on the priorities is identified at the planning meeting.	
Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: • Each resident will attend their GP for a full review and discussion regarding healthcare plans required. Following this discussion required healthcare plans will be put in place.	
Regulation 7: Positive behavioral support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • A practice of locking the front door and the key of the door being placed in the kitchen away from the front door was identified as a restrictive practice for one resident during the inspection. This practice has now been written up has a restrictive practice in line with policy. • Any further restrictions that are put in place will be managed in line with procedure.	
Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: • A risk assessment will be put in place for 1 resident in relation to a history of inaccurate reporting. The risk assessment will be developed in consultation with relevant members of MDT and the designated officer. This risk assessment will provide guidance to staff regarding verbal reports from resident and provide guidance to PIC and PPIM in relation to notifying HIQA.	

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 10(3)(a)	The registered provider shall ensure that each resident has access to a telephone and appropriate media, such as television, radio, newspapers and internet.	Substantially Compliant	Yellow	31/12/2018
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	31/08/2018
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Not Compliant	Orange	31/08/2018
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the	Not Compliant	Orange	31/08/2018

	fees to be charged.			
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	06/06/2018
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	31/05/2018
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	31/05/2018
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	31/05/2018
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/05/2018
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/12/2018
Regulation 28(3)(b)	The registered provider shall make adequate arrangements for giving warning of fires.	Substantially Compliant	Yellow	31/05/2018
Regulation 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other	Not Compliant	Orange	31/08/2018

	medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.			
Regulation 29(5)	The person in charge shall ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability.	Not Compliant	Orange	29/06/2018
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	31/08/2018
Regulation 31(1)(d)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any serious injury to a resident which requires immediate medical or hospital treatment.	Not Compliant	Orange	04/05/2018
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	04/05/2018
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring	Not Compliant	Orange	30/06/2018

	in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.			
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Substantially Compliant	Yellow	16/05/2018
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Substantially Compliant	Yellow	16/05/2018
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Substantially Compliant	Yellow	16/05/2018
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Not Compliant	Orange	03/08/2018
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	31/12/2018
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	Substantially Compliant	Yellow	15/08/2018

	agreed timescales.			
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	12/09/2018
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.	Substantially Compliant	Yellow	30/06/2018
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Substantially Compliant	Yellow	28/07/2018