Office of the Chief Inspector

Report of an inspection of a Designated Centre for Older People

<table>
<thead>
<tr>
<th>Name of designated centre:</th>
<th>The Croft Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of provider:</td>
<td>Croft Nursing Home Limited</td>
</tr>
<tr>
<td>Address of centre:</td>
<td>2 Goldenbridge Walk, Inchicore, Dublin 8</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>07 June 2019</td>
</tr>
<tr>
<td>Centre ID:</td>
<td>OSV-0000028</td>
</tr>
<tr>
<td>Fieldwork ID:</td>
<td>MON-0026105</td>
</tr>
</tbody>
</table>
About the designated centre

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

The Croft Nursing Home is located just a few miles from the city centre and within walking distance of Inchicore village. The home is a single storey building providing accommodation for 37 long stay beds. Accommodation is configured to address the needs of all potential residents and includes superior single, companion and shared accommodation with assisted bath and shower rooms. There are a number of lounges and reading areas located throughout the building. The centre also has access to a secure garden area for residents to use.

The following information outlines some additional data on this centre.

| Number of residents on the date of inspection: | 37 |
How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 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:

<table>
<thead>
<tr>
<th>Date</th>
<th>Times of Inspection</th>
<th>Inspector</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>07 June 2019</td>
<td>08:25hrs to 16:30hrs</td>
<td>Michael Dunne</td>
<td>Lead</td>
</tr>
</tbody>
</table>
What residents told us and what inspectors observed

The inspector spoke with many residents during the inspection and most residents spoken with were happy with the quality of care and support they were receiving. Residents stated that they were content with the choice and quality of food provided. The inspector observed a meal service and saw that residents were receiving the required support to enjoy their meal. Staff provided person centre support to residents who required assistance with eating in a sensitive and supportive manner.

Residents also mentioned that they felt safe in the home. They indicated that if they had a problem with any aspect of the service they could speak to any staff member. The person in charge had an open-door policy in place where residents could come and speak with them directly. There were few limitations on residents receiving visitors and it was evident that family and friend’s involvement in residents lives was promoted and encouraged. A family member who spoke with the inspector stated that when they raised an issue about the care of their partner the staff team worked closely with them to resolve the issue.

Staff were observed knocking on resident’s door before entry and explained the purpose of their visit. Residents said that they were happy with staff support when they received assistance with personal care duties. One resident said 'I don’t know what I would do without them'.

There were a range of activities being provided on the day of the inspection. Residents were observed being supported to attend group activities while others remained in their rooms pursuing their own interests. There were sufficient numbers of staff available to ensure residents were supported to play an active part in the activities provided.

Residents told the inspector that they liked their room environments and said that they could personalise them if they wished. They indicated that they were happy with the fixtures and fittings in their rooms and added that staff were effective in managing repairs and maintenance.

Capacity and capability

This was a well-managed centre where systems were in place to review the quality and safety of care provided. The statement of purpose accurately described the
services and facilities offered by the provider. There was a well-defined management structure in place which provided effective leadership in the delivery of care services. The person in charge was well established in their role and was assisted by an assistant director of nursing along with clinical nurse managers in the delivery of care support. There were also systems in place to audit and monitor the effectiveness of clinical interventions.

The centre managed its resources effectively where staffing cover was arranged through their own bank of locums, this provided a continuity of service to the residents living in the centre. A review of rosters past and present indicated that all vacant shifts had been covered in line with staffing levels indicated in the statement of purpose. Permanent staff were well supervised and had received regular training in key areas such as fire training and safeguarding.

The home environment was suitable to meet the needs of the residents and was arranged in such a manner that residents could access facilities without hindrance.

There were effective systems in place to manage and use information effectively. It was also noted that recording keeping was of a high standard making information retrieval an easy process.

**Regulation 15: Staffing**

There were sufficient numbers of staff with the required skill-mix available to provide the required levels of support to the residents. The staffing complement was consistent with the numbers identified in the statement of purpose. There were sufficient resources available to ensure that all staff received the required level of supervision. Rosters past and present were reviewed and those seen indicated that all shifts were covered when vacancies occurred. The person in charge informed the inspector that the centre did not employ agency staff to cover shifts but used their own bank of locum staff instead. This provided continuity of care to the residents with having staff available who were familiar to them and aware of their individual needs.

**Judgment:** Compliant

**Regulation 16: Training and staff development**

A review of the staff training matrix showed that staff had received mandatory training such as safeguarding, fire training, moving and handling. In addition there was additional training available in dementia care, behaviours that challenge and infection control. Clinical staff received training in wound management, weight
loss, medication management and cardiopulmonary resuscitation (CPR). There was also access to e-learning courses specifically designed for nursing staff. The inspector spoke with many staff members in the course of the inspection and they were able to give examples of how their daily practice was informed by the training they attended. In particular staff were able to give good examples of what safeguarding meant within a care home environment and on how their role played a vital part in ensuring residents were protected.

Judgment: Compliant

**Regulation 19: Directory of residents**

There was a directory of residents available for review. The centre had collated information about residents as detailed in schedule three of the regulations. The directory was current and presented in a manner that was easy to follow and review.

Judgment: Compliant

**Regulation 21: Records**

This inspection of records focused on schedule two of the regulations. The inspector reviewed staff records and found that records reviewed contained all the required information as set out in schedule two of the regulations. Records were stored appropriately and presented in a format easy to follow and review.

Judgment: Compliant

**Regulation 23: Governance and management**

There was a clear management structure in place with the person in charge being supported in their role by the assistant director of nursing. There was additional management oversight provided by the clinical governance manager who paid regular visits to the centre. Individual roles and responsibilities were clear and there were meetings held on a regular basis to ensure that the care home was meeting its obligations. There were a range of audits providing clinical oversight such as review of falls, weight monitoring, dependencies and the centre was using information gained from these audits to improve care intervention.

There were adequate resources available in the centre in order to provide a safe and
consistent service. There were sufficient numbers of staff available who were suitably trained to provide appropriate levels of support to the residents. The premises were clean with communal spaces tastefully decorated for residents to enjoy.

There was an annual review of quality and safety completed for 2018-2019. The centre consulted with key stakeholders which included engaging with residents and relatives by means of a satisfaction survey. The centre incorporated views and comments gained from these surveys into the annual review of quality and safety.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose was found to give an accurate description of the services provided at the centre. The current statement of purpose was reviewed in 2019 and was available for for residents and relatives to review.

Judgment: Compliant

Regulation 30: Volunteers

The centre was not in receipt of support from volunteers at the time of the inspection however the person in charge was aware of their responsibilities with regard to vetting and supervising volunteers.

Judgment: Compliant

Regulation 34: Complaints procedure

The centre had a complaints policy in place which met the requirements of the regulations. The policy outlined the key steps involved in how to register a complaint and detailed the processes of investigation, feedback and appeal. The policy was advertised in a key location and was available for residents and visitors to review.

The centre had recorded 12 complaints since the previous inspection in May 2018. A review of records indicated that all these complaints had been thoroughly investigated with relevant and timely feedback issued to each complainant. There was no evidence to suggest that any complainant suffered adversely from raising a complaint. The inspector spoke with a family member who had registered a
complaint earlier this year. The family member felt that they were listened to and commended the management on their timely response in dealing with the issue.

Judgment: Compliant

**Quality and safety**

Overall the inspector found that this was a well-managed service with positive health and social care outcomes for the residents. There were some improvements needed to ensure that residents who required support due to behaviours that challenge received timely support and intervention from staff.

There were comprehensive assessments in place which identified residents' health and social care needs. Care plans were created to meet those needs and took account of residents' choices and preferences. Care plans were found to be well constructed and easy to follow. These plans were reviewed on a regular basis however care plans reviews seen did not give sufficient detail or analysis of how effective interventions were in meeting the identified needs.

There was a good selection of communal spaces where residents could meet relatives outside of their room environments. The conservatory was popular with residents and was tastefully decorated. Toilets and bathrooms were clean and suitable for residents using mobility aids. There were handrails located throughout the building to assist residents with poor mobility. There was good signage and information available in the centre to orientate residents around the centre and to inform them of planned activities. The inspector observed a bingo session which was very popular with the residents with many in attendance.

Resident rooms were decorated to a good standard and some residents had personalised their bedrooms to make them more homely. Residents had access to a lockable cupboard and adequate storage space.

There was a focus on promoting health and safety in the centre and on the whole this was well managed' however, the inspector noted that a risk assessment had not been updated with regard to residents with exit seeking tendencies. Fire management policies and procedures were well established with staff appropriately trained in fire safety. There were improvements required with regard to ensuring fire door checks were included in the weekly fire check. In addition the recording of information resulting from fire drills required more detail so as to allow for any learning that may be identified.

The inspector noted that areas of the service which required action from the previous inspection had been addressed.
**Regulation 17: Premises**

The premises were suitable for the needs of the residents living in the centre. Accommodation was provided in a range of single and shared bedrooms with all provision provided on ground floor level. The premises were clean and there was evidence that the centre had good cleaning systems in place to maintain good hygiene levels. Communal areas were well presented and available for residents to use. The centre was adequately lit with appropriate signage located in key locations to orientate residents and visitors around the building.

Residents had access to a secure garden at the rear of the centre. Resident bedrooms were tastefully decorated and contained adequate space for storage of personal items. A smoking room was located in an appropriate part of the building and contained appropriate fire monitoring equipment. Residents were observed using this facility throughout the day.

There was limited storage space available in the centre however equipment viewed during the inspection was stored appropriately. The centre had developed a separate facility for the charging of hoists.

Judgment: Compliant

**Regulation 26: Risk management**

There was a risk management policy in place which detailed the centre's control measures in managing risk in the centre. There was a risk register in place which identified risks from an operational and clinical perspective. The centre was proactive in managing risk which included an ongoing review of risks throughout the year. When new risks were identified they were added to the risk register. There was a system in place for the management and review of serious incidents which included oversight from the clinical governance manager and the operations manager. Risk assessments viewed during the inspection were constructed in a manner which identified the potential hazard and the control measures in place to mitigate or control the hazard.

There were risk assessments in place for the control of abuse, aggression and violence, accidental injury to residents, visitors or staff and for self-harm. The centre also had a contingency plan to deal with unexpected events in order to ensure consistency of service.

A potential hazard was identified by the inspector on the day of the inspection, this was brought to the attention of the management team who put measures in place to resolve the issue immediately.

The centre recently dealt with an incident of abscondion and had dealt with this...
issue effectively in terms of investigation and follow up. However, the risk register was not updated to reflect new interventions to mitigate this risk going forward.

Judgment: Substantially compliant

**Regulation 28: Fire precautions**

The provider had ensured that there were measures in place to protect residents from the risk of fire. There were systems in place to ensure that staff had received fire training while the head of the maintenance team had received additional fire management training. There were service contracts in place to monitor the use of fire equipment. Records seen on site confirmed that a fire system check was completed recently. There were also recent checks on emergency lighting, fire extinguishers and electrical equipment checks.

Fire exits viewed were clear of obstruction while fire directional signage led one to the nearest emergency exit. There was an internal smoking room which was monitored by staff on a regular basis. This room contained the required equipment to contain a fire such as a fire blanket and fire extinguisher.

Information was seen which confirmed that the centre had carried out regular fire drills; however, improvements were needed in the recording of these drills with a focus on identifying areas for potential learning. Fire doors checked as part of the centre orientation uncovered a number of fire doors which did not close properly, this was brought to the attention of management who confirmed that this would be dealt with as a matter of priority.

Judgment: Substantially compliant

**Regulation 5: Individual assessment and care plan**

A number of care plans were reviewed and all those seen had a pre-assessment in place prior to the residents being admitted to the centre. Relatives spoken with during the inspection confirmed that they were aware of their relatives care plan and confirmed that the resident was consulted prior to its construction.

Care plans were created on the findings of the pre-assessments and detailed how the centre was going to meet those specific needs. There was evidence available to show that when an intervention needed to change then the relevant care plan was updated accordingly. Those care plans seen were well constructed, clear in identifying what needed to be done and provided for easier monitoring. The centre did review care plans at the required time however improvements were required in relation to the level of detail contained in these reviews. Those seen did not give
an informative account of the effectiveness of care interventions to date or incorporate resident views as part of the overall care plan review.

Judgment: Substantially compliant

Regulation 6: Health care

Resident records seen confirmed that residents had good health-care outcomes. The centre maintained residents' well being by a good standard of evidence-based care. Residents' health-care needs were identified through a comprehensive assessment and intervention to meet those needs were identified and monitored through effective care planning. There were arrangements in place to access specialist input such as psychiatric care for the elderly and medical input through a visiting doctor. Records seen as part of the inspection indicated that staff followed the advice of specialists in ensuring that recommended treatment was updated in individuals care plans.

Residents also had access to a range of primary health care services provided locally by the HSE (Health Service Executive). Where residents required a referral for an occupational therapist assessment or input this was routed through the HSE while arrangements were in place for a physiotherapist to visit every two weeks or more often as required.

Access to allied health care input such as tissue viability nursing, dietician and speech and language therapy was organised through a private company. The centre has arrangements in place for a mobile dental service to provide support for residents oral hygiene.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Records reviewed indicated that staff had received mandatory training in this area in order to provide them with the skills necessary to care for residents who had responsive behaviours. Discussions with staff revealed that they were knowledgeable around issues of safeguarding and abuse. In addition staff were able to give examples of where their interventions could be restrictive and impact on residents' individual choice and autonomy.

During the inspection it was noted that one resident continued to call out. It was also noted that this resident was in a shared room and intervention was slow in terms of providing the necessary support. This resident required one-to-one supervision and it was seen later in the day that they were not in receipt of the
required level of supervision or staff support.

Judgment: Substantially compliant

**Regulation 8: Protection**

The registered provider ensured that staff had received training in key areas such as safeguarding and dementia care. Discussions with staff indicated that they were aware of their role in relation to keeping residents safe from abuse. Staff records reviewed as part of the inspection indicated that those staff had the required Gardai Siochana (police) vetting prior to taking up employment along with a range of other checks such as checks on employment histories and identification checks. There were no safeguarding investigations to review; however the person in charge was aware of their role with regards to investigation and follow up with appropriate referrals where required. Residents spoken with said they felt comfortable in the centre. When asked if they ever wanted to raise a concern they were able to indicate they would approach the person in charge directly.

Judgment: Compliant

**Regulation 9: Residents' rights**

Residents were able to exercise choice in many aspects of their care. They were consulted as part of the care planning process and where extra support was required to do this it was provided. Resident views as to how they would like to receive personal care was incorporated into their respective care plan and residents had an overall say in the quality of services provided through responding to the satisfaction surveys provided by the centre. There were regular team meetings where topics of interest were discussed such as meal provision and outings. Advocacy services were provided by an in house advocacy services manager who could refer on to external services if required.

There were few restrictions placed on visitors allowing residents to keep in touch with their relatives.

Residents were provided with a residents information guide which clearly set out the services on offer and covered many key aspects of living in the centre such as access to health and social care support. There was an extensive programme of activities on offer in the centre with activity provision covering the full week and provided by dedicated activity workers. Residents who wished to pursue their own individual interest were supported to do so.

Residents spoken with confirmed they had access to social media including TV, s,
newspapers and many indicated that they had voted in recent elections.

Residents in shared rooms had their privacy and dignity respected through the provision of appropriate screening.

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 Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

<table>
<thead>
<tr>
<th>Regulation Title</th>
<th>Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Capacity and capability</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 15: Staffing</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 16: Training and staff development</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 19: Directory of residents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 21: Records</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 3: Statement of purpose</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 30: Volunteers</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 34: Complaints procedure</td>
<td>Compliant</td>
</tr>
<tr>
<td><strong>Quality and safety</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 17: Premises</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 26: Risk management</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 28: Fire precautions</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 5: Individual assessment and care plan</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 6: Health care</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 7: Managing behaviour that is challenging</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 8: Protection</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 9: Residents' rights</td>
<td>Compliant</td>
</tr>
</tbody>
</table>
Compliance Plan for The Croft Nursing Home
OSV-0000028

Inspection ID: MON-0026105

Date of inspection: 07/06/2019

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 Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

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. Specific to that regulation, Measurable so that they can monitor progress, Achievable and Realistic, and Time 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>
<thead>
<tr>
<th>Regulation Heading</th>
<th>Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 26: Risk management</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outline how you are going to come into compliance with Regulation 26: Risk management:</td>
<td></td>
</tr>
<tr>
<td>The Risk register has been updated to reflect the additional interventions to mitigate the risk of abscondion from the centre. The risk register will be reviewed as required based on assessments and incidents as they occur.</td>
<td></td>
</tr>
<tr>
<td>Regulation 28: Fire precautions</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outline how you are going to come into compliance with Regulation 28: Fire precautions:</td>
<td></td>
</tr>
<tr>
<td>Following on from discussions with our Fire Consultant and Training Provider we have requested that where areas for improvement are identified during drills that there is clear focus on the potential learning outcomes to be addressed at future drills. We are reviewing how the drill report form may be improved to allow for more narrative to facilitate this.</td>
<td></td>
</tr>
<tr>
<td>Any defects identified during the inspection were dealt with the following day and we have also introduced a number of specific actions in terms of door checks to be audited on a monthly basis with every door in the home having its own unique identifier code for ease of reference.</td>
<td></td>
</tr>
<tr>
<td>Regulation 5: Individual assessment and care plan</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:</td>
<td></td>
</tr>
<tr>
<td>All residents care plans have been reviewed. A schedule is in place to update each review and evaluation section of our residents care plans. Each review and evaluation section will reflect the care been given and its effectiveness in meeting the identified care need. The care plans will continue to be reviewed on a 3 monthly basis.</td>
<td></td>
</tr>
<tr>
<td>Regulation 7: Managing behaviour that is challenging</td>
<td>Substantially Compliant</td>
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Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:

Each resident that has been identified as requiring additional supports due to responsive behaviours now have a detailed care plan in place. The care plans are reviewed and discussed with the residents, family, GP, Psychiatry of old age (where necessary) and with the activities coordinator. The care plan aims to guide and support staff to meet the responsive needs in a calm and supporting manner. If the behaviours noted require a single room the PIC will arrange one as soon as possible. In the case identified by the inspector this review took place and the residents is now accommodated in a single room.
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).

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Regulatory requirement</th>
<th>Judgment</th>
<th>Risk rating</th>
<th>Date to be complied with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 26(1)(a)</td>
<td>The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>20/06/2019</td>
</tr>
<tr>
<td>Regulation 28(1)(c)(iii)</td>
<td>The registered provider shall make adequate arrangements for testing fire equipment.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>31/08/2019</td>
</tr>
<tr>
<td>Regulation 28(1)(d)</td>
<td>The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>31/08/2019</td>
</tr>
<tr>
<td>Regulation 5(4)</td>
<td>The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident’s family.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>31/07/2019</td>
</tr>
<tr>
<td>Regulation 7(1)</td>
<td>The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.</td>
<td>Not Compliant</td>
<td>20/06/2019</td>
<td></td>
</tr>
</tbody>
</table>