Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Lee View
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Short Notice Announced
Date of inspection:	07 September 2021
Centre ID:	OSV-0005517
Fieldwork ID:	MON-0029651

About the designated centre

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

Lee View provides a full-time residential service to two adult residents. The provider aims to provide an environment that is viewed as home where resident's individuality and choices are respected and promoted. Residents are supported to be active participants in the running of their home and to lead purposeful lives integrated into their local community. The support provided is informed by the process of individualised assessment and planning. The model of support is social and the staff team is comprised of a social care worker and support staff, led and directed by the person in charge. There is a minimum of one staff on duty at all times and this increases to two for periods during the week and at weekends, to support resident independence and individuality. The premises is a semi-detached dormer-type property in a mature residential area on the outskirts of the busy town; the location offers access to a broad range of suitable amenities. There is adequate parking to the front and a pleasant garden to the rear of the premises.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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
Tuesday 7 September 2021	10:00hrs to 17:00hrs	Mary Moore	Lead

What residents told us and what inspectors observed

The service provided was responsive to the individual needs of each resident. Residents enjoyed a good quality of life and, there was a clear objective to provide support to further improve that quality of life. This inspection did identify areas where improvement was needed such as the overall maintenance of the premises, oversight of medicines practice and, of the procedures that tested the centre's evacuation procedures.

This inspection was undertaken in the context of the ongoing requirement for measures to prevent the accidental introduction and onward transmission of COVID-19. The limited space in the house challenged the ability to maintain a safe physical distance from staff and residents so records were reviewed and, the person in charge was spoken with, in another location facilitated by the provider. The inspector went to the house in the afternoon but did not meet with the residents as one resident attends an external day service and, the other resident had a planned personal appointment. The inspector has met with both residents on previous inspections of this centre.

On reviewing the report of the internal annual service review, the inspector saw that feedback from residents and their representatives had been sought to inform the review. It was reported that representatives had declined to complete a formal questionnaire but said that they were very happy with the service provided. The internal auditor during the most recent internal six-monthly review had actively sought representative feedback and, the representative spoken with was reported to be very happy with the service.

Staff had recorded in a very informed way, taking into account the communication abilities of each resident, how they had sought feedback from residents and, how residents had responded to each question asked. For example, when asked about their input into their personal plan and, the choice and control that they had in their daily lives, residents showed staff their accessible plan on their personal device and, indicated how they choose their own clothes to wear each day. Residents said that they liked living in the house and, with each other. Residents identified particular persons in their circle of support that they would speak with if they were not happy. There was a risk assessment, clear plans and reporting protocols for occasions when a resident raised concerns about their service.

The person in charge and staff spoken with confirmed that visits to the centre and, visits to home had recommenced with reasonable controls so that visits were safe in the context of the risk posed by COVID-19. Records seen confirmed that visits deemed essential to the residents overall well-being were always facilitated with staff and families agreeing any controls necessary such as the use of personal protective equipment (PPE). Residents also had access to a range of media that were used to support contact with family and friends, with life in general and, to forums such as the internal advocacy forum. Staff said that a resident had recently

been invited to return to their supported employment in the community and, this would be progressed by the day service if the resident wished to return.

The design and layout of the house was suited to the number and needs of residents living in the house and allowed them to have separate personal and private space. However, the inspector saw that the house was in need of a general upgrade and redecoration. The inspector noted that the self-closing devices for the fire resistant doors, needed at the time of the last HIQA (Health Information and Quality Authority) inspection had been fitted. However, there was some slight damage to the intumescent strip of one such door. Also, improvement was needed in the scheduling of simulated drills so that they adequately tested the evacuation procedures in light of identified challenges.

As stated at the outset of this report, it was evident to the inspector that the objective of management was to ensure residents lived the best life possible, particularly where COVID-19 had exacerbated pre-existing anxieties and routines. This was spoken of in a way that demonstrated respect for the challenge that this posed for both resident and staff, the need for time and paced progression was understood. The personal plan including the positive behaviour support plan were current and, the strategies to be used on a daily basis to support the resident to adapt to new routines were described by staff spoken with. Additional support in the form of reflective practice had been made available to staff.

Overall, there was much evidence of good governance that focussed on each resident, their quality of life and, the quality and safety of the support and service that they received. Many of the arrangements in place supported the provision of a safe, quality service. For example, the provider had appointed suitable persons to manage and oversee the service, that oversight was informed and person centred. The centre presented as adequately resourced, for example staffing levels were adequate. However, the findings of this inspection in relation to medicines management, fire safety and, the general upkeep of the premises indicated a need for improvement in these areas but also a need for better day-to-day oversight so that deficits were addressed and corrected in a timely manner.

The next two sections of this report will present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

There was much evidence that there were management systems in place to ensure that the service provided was safe and, appropriate to residents' needs. The centre presented as adequately resourced to deliver on its stated objectives. The provider had systems of review that it effectively used to monitor and improve the quality and safety of the service. Over the course of HIQA (Health Information and Quality

Authority) inspections, the provider has demonstrated a high level of compliance with regulatory requirements. However, while a good level of compliance with the regulations was also identified on this inspection, improvements were required in the areas of medicines management, fire safety and, the general maintenance of the house. The nature of the findings indicated a need for better, practical day-to-day oversight so that there was adequate and timely identification, reporting and, correction of issues that arose.

The management structure was clear and, individual roles and responsibilities were understood. For example, the person in charge maintained a clear line of communication to their line manager and, provided support and supervision to the staff team. It was evident from speaking with the person in charge and, from records reviewed that the person in charge was consistently engaged in the management and oversight of the service. Staff supervisions and appraisals were reported to be on schedule and, staff meetings, where there was good discussion of each resident's well-being, were regularly convened. The annual review of the service for 2020 had been completed in a timely manner and, the six monthly unannounced reviews were also, based on records seen, completed on schedule. The findings of these internal reviews were generally satisfactory and, found that any quality improvement plans were satisfactorily progressed. For example the most recent review had identified some overdue refresher training and, this training was now scheduled. Additional systems of review and oversight included audits of medicines management, of infection prevention and control practice and, of any incidents and accidents that occurred.

However, the findings of this HIQA inspection indicated a requirement for more robust day-to-day oversight to complement the more structured systems of review. This was needed so that deficits and failings were identified and corrected in a timely manner. For example, the inspector noted from records seen, a medicines error in the days prior to this inspection. The error while noted by staff had not been reported in line with internal procedures and, consequently it was not evidenced that it had been investigated to establish if it was a recording or administration error. A further example was the failure to ensure that simulated evacuation drills were scheduled to reflect evacuation challenges in the centre and, to ensure that both residents participated regularly in a drill in the centre.

It was evident from records seen that residents did not like change including any changes to the staff team. Some change as discussed with the person in charge was unavoidable. The inspector reviewed the staff rota and saw that there was good consistency of staffing. The staff team was described by the person in charge as skilled and experienced but also committed to change. Ordinarily, there was one staff member on duty at all times but two staff were regularly on duty to support individual resident choices and routines.

Notwithstanding the challenge to providing staff training that had been presented by COVID-19, attendance at staff training was high, including the completion of on-line training. Any refresher training that was overdue was now booked. In addition, staff had access to reflective practice and, to members of the multi-disciplinary team (MDT) such as the behaviour support specialist and, the designated safeguarding

officer, to support and guide them in their work.

Regulation 14: Persons in charge

The person in charge worked full-time and had the qualifications, skills and experience required for the role. The person in charge had a solid understanding of their management and oversight responsibilities, had a clear objective to provide each resident with the best possible service and, had put the arrangements in place to deliver on this.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels, staffing arrangements and, skill-mix were suited to the number and, the assessed needs and abilities of the residents. A planned and actual staff rota showing the staff on duty each day and night and, the hours that they worked was maintained.

Judgment: Compliant

Regulation 16: Training and staff development

Overall staff attendance at mandatory, required and desired training was good. Some refresher training was overdue but this was now scheduled.

Judgment: Compliant

Regulation 23: Governance and management

The findings of this HIQA inspection indicated a requirement for more robust day-to-day oversight to complement the more structured systems of review. This was needed so that deficits and failings were identified and corrected in a timely manner

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The contract for the provision of support and services was centre specific and, resident specific. The contract included the fees to be charged. However, it was not signed as agreed with the resident or their representative.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Based on the records seen in the centre of accidents and incidents that occurred, there were adequate arrangements that ensured HIQA was notified of certain events such as the use of any restrictive intervention.

Judgment: Compliant

Quality and safety

The support provided was tailored to the individual needs and abilities of each resident. Access to training, to the MDT and, other relevant clinicians ensured the evidence base of the care and support provided. Residents and their representatives had input into the plan of support and, residents had good choice and control over their daily routines. There was a shared objective to provide support that improved outcomes for residents. However, improvement was needed in the oversight of medicines management practice, evacuation procedures and, the general maintenance of the premises.

The inspector saw that the personal plan was current and was based on the assessment of resident needs and abilities. Residents and their representatives had input into the plan and, the plan was available to the resident in an accessible format. The plan included the residents' personal objectives for the coming year, the time-fame for their completion and, the staff responsible for progressing each goal. The objective of the plan was to respect the individuality, the assessed needs and choices of the resident while achieving the best possible quality of life outcomes with and, for the resident.

In that context the positive behaviour support plan had recently been reviewed by the behaviour support specialist in consultation with the staff team. The plan was informed by the analysis of data collected by staff. The person in charge described to the inspector how staff were actively encouraged to report all incidents that occurred so that data on responses and interventions that worked and, those that

did not, was collated. The support provided was therapeutic and there were no reported restrictive practices in routine use and, none were identified by this inspection. Staff spoken with described the strategies in use to support good resident decision making and, ultimately better routines.

The positive behaviour support plan outlined the behaviours that were exhibited, possible triggers and, their meaning. This included language and statements that could be used at times and, that could be interpreted as a safeguarding concern. There was no ambiguity in the plan between the required staff response to such statements and, the provider's responsibility to ensure that residents were at all times safe from harm and abuse.

The personal plan also included the residents' healthcare needs; the care provided in response was advised by the appropriate clinicians. Staff monitored resident well-being and ensured the resident had access to these clinicians as needed such as their General Practitioner (GP), psychiatry, neurology and, dental care. Clinicians monitored the effectiveness of prescribed medicines.

All staff had completed medicines management training and, medicines management practice was regularly audited. Staff administered medicines based on the findings of an assessment of risk and resident ability to safely manage their own medicines. However, records seen by the inspector indicated that medicines had either not been administered or, were not recorded as administered on one occasion in the days prior to this inspection. This omission had not been reported and addressed in line with the provider's incident reporting procedures. In addition, a prescription seen was of poor quality including the use of obliterating fluid to correct errors made. The evidence available to the inspector was that this was not done in the centre. Medicines management oversight should however ensure appropriate and suitable practices in all aspects of medicines management.

The location, design and layout of the house was suited to the number and needs of the residents accommodated. However, as stated in the opening section of this report it was evident that some areas of the house were in need of refurbishment and redecoration with general signs of wear and tear including chipped paintwork, the general presentation of the rear sitting room, damaged flooring and, a loose floor tile. The maintenance of the house had been discussed at a recent staff meeting. More specific matters were discussed with the person in charge and, the community services manager at verbal feedback of the inspection findings.

There was evidence of good fire safety management systems including an annual review of simulated drills to identify both good practice and, areas where improvement was needed. The inspector saw from records in place that the fire detection and alarm system, the emergency lighting and, the fire-fighting equipment were all inspected and tested at the required interval. All staff had completed fire safety training. Simulated drills were regularly convened and, these drills had identified that one resident may not respond to the alarm or to the request from staff to evacuate. This was risk assessed and, was also included in the centre and, in the residents' emergency evacuation plans (CEEP and PEEP). The strategies to be used by staff to promote evacuation were also specified in these plans. The resident

had been provided with fire safety training to enhance their understanding of the importance of evacuating when asked to do so by staff. However, the records maintained of subsequent simulated drills did not establish if the resident had since participated in another drill in the centre to test the success of the training provided; the residents were not always identified on the completed record. Staff spoken with confirmed that the resident was not present in the centre for the most recent drill. There were internal and external systems for reviewing fire safety precautions but the inspector noted some damage to the intumescent strip of one fire-resistant door.

While the inspector did recommend some expansion of the risk register, overall the risk register was centre specific and resident specific. There was good co-relation between risks identified and, the assessed needs of each resident including the positive behaviour support plan. The occurrence of incidents was seen to inform the evaluation of risk and, the need for any additional controls.

There was a suite of risk assessments specific to COVID-19 and, the measures needed to prevent its accidental introduction to the centre and its onward transmission. For example, there was a risk assessment for safe community access, for returning to external day services and, for facilitating visits to the centre and to home. As stated in the previous section of this report, all staff had completed the required infection prevention and control training and, residents were described as having a good understanding of the risk and how to protect themselves such as using a face mask in certain situations. Staff and resident well-being was monitored, there was an enhanced schedule of environmental cleaning and plans for responding to any suspected or confirmed COVID-19.

Regulation 10: Communication

The personal plan included the communication style and ability of the resident and any support needed to ensure effective communication. The interdependent role of communication and behaviour was clearly outlined in the positive behaviour support plan. Residents had access to and enjoyed a range of media.

Judgment: Compliant

Regulation 11: Visits

The importance of visits to resident well-being was understood. Reasonable controls were implemented so that visits were safely facilitated.

Judgment: Compliant

Regulation 13: General welfare and development

The care and support provided respected the nature and, the extent of the residents disability and, their assessed needs, but also sought to facilitate the best possible outcomes for residents. Residents had access to their family, their community and, if they wished, could experience volunteering and employment.

Judgment: Compliant

Regulation 17: Premises

Some areas of the house were in need of refurbishment and redecoration with general signs of wear and tear including chipped paintwork, the general presentation of the rear sitting room, damaged flooring and, a loose floor tile.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The risk register was centre specific and resident specific. There was good co-relation between risks identified and, the assessed needs of each resident. The occurrence of incidents was seen to inform the evaluation of risk and, the need for any additional controls.

Judgment: Compliant

Regulation 27: Protection against infection

In response to the risk posed by COVID-19, the provider had local and national policy, a range of centre specific and resident specific risk assessments and, contingency plans.

Judgment: Compliant

Regulation 28: Fire precautions

Simulated drills had identified that one resident may not respond to the alarm or to the request from staff to evacuate. The records of subsequent simulated drills did not establish if the resident had since participated in another drill in the centre to test the success of training provided. There were internal and external systems for reviewing fire safety precautions but the inspector noted some damage to the intumescent strip of one fire-resistant door.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Medicines had either not been administered or, were not recorded as administered on one occasion in the days prior to this inspection. This omission had not been reported and addressed in line with the provider's incident reporting procedures. In addition, a prescription seen was of poor quality including the use of obliterating fluid to correct errors made.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The personal plan was current and, was based on the assessment of resident needs and abilities. Residents and their representatives had input into the plan and, the plan was available to the resident in an accessible format. The plan included the residents' personal objectives for the coming year, the time-fame for their completion and, the staff member responsible for progressing each goal. The plan was further informed by input from the MDT.

Judgment: Compliant

Regulation 6: Health care

Staff monitored resident well-being and, ensured residents had access to the services and clinicians needed so that the resident enjoyed good health.

Judgment: Compliant

Regulation 7: Positive behavioural support

The positive behaviour support plan had recently been reviewed by the behaviour support specialist in consultation with the staff team. The support provided was therapeutic and, there were no reported restrictive practices in routine use and, none were identified by this inspection.

Judgment: Compliant

Regulation 8: Protection

All staff had completed safeguarding training. Residents were supported to develop their knowledge of safeguarding matters and had access as needed to the designated safeguarding officer. There were clear protocols in place for staff as to how to respond to and report any concerns arising.

Judgment: Compliant

Regulation 9: Residents' rights

The operation of the service and the support provided respected the individuality of each resident. While there was an objective to achieve better outcomes for residents, there was respect for resident choice and decision making and, residents had good control over their daily routines. Residents were consulted with about the support that was provided. Residents knew who to complain to if they were not happy and, had access to the internal advocacy forum. The plan for the provision of personal and intimate care strongly referenced respect for resident ability, independence and privacy.

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
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	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Lee View OSV-0005517

Inspection ID: MON-0029651

Date of inspection: 07/09/2021

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: PIC has developed schedule of regular and unannounced site visits to ensure increased oversight at the center. Daily records have been reviewed and staff provided with specific feedback and a guidance document for their reference in improving quality of record in the center. Quality improvement goals have been integrated into the staff appraisals which will be fully completed on 15/10/2021.	
Regulation 24: Admissions and contract for the provision of services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services: The individual's representative has been provided with a copy of the contract for provision of services and has approved and signed same. 13/9/2021	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: A scope of works for improvements to the premises has been completed by a suitably	

qualified person and tender process commenced. Works are planned for roof repair, window repair, redecoration of 2 bedrooms, 1 sitting room and utility room for completion before year end. Some temporary repairs / interim measures have been put in place to ensure safety and comfort of the residents until works are completed.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire door strip repaired 25/9/21.
Scheduled fire drill completed 30/9/2021.
Staff are engage in re training in relation to drill recording and associated risk assessment and drill schedules in place.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Medication omission investigated at the time of the inspection and resolved as staff clerical error. Staff trained in appropriate documentation of medication administration discrepancies and any investigation completed in relation to same. Completed 11/9/2021.
1 medication record is required to be reviewed by a medical professional to ensure it meets the required standard.

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 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/12/2021
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	30/09/2021
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident	Substantially Compliant	Yellow	13/09/2021

	is not capable of giving consent, the terms on which that resident shall reside in the designated centre.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	30/09/2021
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	30/09/2021
Regulation 29(4)(b)	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 medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and	Substantially Compliant	Yellow	15/10/2021

	to no other resident.			