Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

# Office of the Chief Inspector

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

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| Name of designated centre: | Grangemore Rise |
| Name of provider: | St. Michael's House |
| Address of centre: | Dublin 13 |
| Type of inspection: | Unannounced |
| Date of inspection: | 06 December 2018 |
| Centre ID: | OSV-0002341 |
| Fieldwork ID: | MON-0025570 |

## About the designated centre

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

The designated centre is located in in North County Dublin. It is operated by St Michael's House and provides services to seven adults with an intellectual disability who have varied support requirements over the age of 18. The designated centre consists of a house and adjoining apartment. The house is a two storey building and is home to six residents (one on a part time basis) and consists of storage room, toilet, utility room, kitchen, dining room/living room, two bathrooms, two offices and six individual bedrooms. The adjoining apartment is home to one resident and consisted of a kitchen, living/dining room, utility room, staff room, bathroom and bedroom. The designated centre is located close to local shops and transport links. The centre is staffed by a person in charge, nurses, social care workers and care assistants.

**The following information outlines some additional data on this centre.**

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| Current registration end date: | 12/03/2020 |
| Number of residents on the date of inspection: | 7 |

## 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 |
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| 06 December 2018 | 09:00hrs to 17:00hrs | Conan O'Hara | Lead |
| 06 December 2018 | 09:00hrs to 17:00hrs | Amy McGrath | Support |

## Views of people who use the service

The inspectors had the opportunity to meet and spend time with four residents during the inspection. Some residents communicated their thoughts and opinions verbally, others used non verbal methods to communicate. In addition, inspectors met with one family member.

On they day of inspection, some residents appeared relaxed and comfortable in their home. Positive, warm interactions were observed between residents and staff on the day of inspection.

One resident spoke with an inspector and expressed that they had made a complaint about the current living arrangements in the centre.

## Capacity and capability

Overall, there was a clearly defined governance and management system in the centre. However, the provider did not demonstrate that they could meet the combined needs of the residents in this centre. The provider had grouped a number of residents together who required varied levels of support and on the day of inspection the provider did not demonstrate the capacity to meet the combined and individual needs of the residents in a safe and effective way.

There were systems in place for overseeing the centre. For example, the centre was being monitored and audited as required by the regulations. An annual review had been completed as had six monthly unannounced visits to the centre by the provider. Inspectors found from speaking with a number of staff that effective arrangements were not in place to support and facilitate staff to raise concerns about the quality and safety of the care and support provided to residents. In addition, considering the cumulative non compliances identified on inspection, inspectors were not assured that the governance and management arrangements in place ensured a safe and effective service.

The centre maintained a planned and actual roster. From a review of the roster, the inspectors found that there was sufficient staffing levels to meet the needs of the residents. Staff spoken with were knowledgeable of the residents needs and were observed throughout the day of inspection treating residents with dignity and respect. While, inspectors acknowledge that the centre aimed to use regular staff, there was a recent high reliance on relief and agency staff in order to maintain the staffing levels. This did not always ensure the continuity of care for residents. Following the inspection, the inspectors requested assurances from the provider

regarding the continuity of care in the designated centre.

The inspectors reviewed a sample of staff training records and found that not all staff had up-to-date mandatory training such as positive behaviour support and manual handling. In addition, some staff had not received training in breakaway techniques. The provider informed inspectors that this training had been scheduled. This meant that not all staff on the day of inspection were suitably trained to support the assessed needs of the residents.

The inspectors reviewed a sample of incidents and accidents and found that not all incidents of concern were notified to the Office of the Chief Inspector as required by the regulations.

The inspectors reviewed the admission process for the most recent admission to the centre. While the provider demonstrated that there was a consultation process pre and post admission, it was not evident that the admission process followed the provider's admission policy. It was also not evident that where compatibility issues between residents existed that this was being appropriately addressed or managed.

There was a complaints policy in place dated February 2018 and the centre maintained a log of complaints and compliments. The inspectors reviewed the complaints log and found that seven complaints were made in 2018. The complaints related to living arrangements, dissatisfaction with the support provided to family members living in the designated centre, parking of cars and maintenance issues. While some complaints were dealt with on a local level and the satisfaction of the complainant was recorded, it was evident that all complaints were handled in line with the provider's policy.

## Regulation 15: Staffing

There was sufficient staffing levels to meet the needs of the residents. However, there was a high reliance on relief and agency staff which did not always ensure the continuity of care for residents.

Judgment: Not compliant

## Regulation 16: Training and staff development

Not all staff were up-to-date in mandatory training such as manual handling and positive behaviour support. In addition, some staff had not received training in breakaway techniques. This meant that not all staff were suitably trained to support the assessed needs of the residents.

Judgment: Not compliant

## Regulation 23: Governance and management

There was clearly defined governance and management systems in place in the centre however these did not prove to be effective at all times. Effective arrangements were not in place to support facilitate staff to raise concerns about the quality and safety of the care and support provided to residents. In addition, considering the cumulative non compliances identified on inspection, inspectors were not assured that the governance and management systems in place ensured a safe and effective service.

Judgment: Not compliant

## Regulation 24: Admissions and contract for the provision of services

It was not evident that the provider adhered to their own admission process as outlined in their admission's policy.

Judgment: Not compliant

## Regulation 31: Notification of incidents

Not all incidents of concern were notified to the Office of the Chief Inspectors as required by the regulations.

Judgment: Not compliant

## Regulation 34: Complaints procedure

There was a complaints policy in place dated August 2016 and the centre maintained a log of complaints and compliments. While some complaints were dealt with on a local level and the satisfaction of the complainant was recorded, it was evident that all complaints were handled in line with the provider's policy.

Judgment: Not compliant

## Quality and safety

Overall, the quality and safety of the services was not appropriate and required improvements to ensure the service provided to residents was of good quality and residents were safeguarded. Areas requiring improvement included safeguarding, personal plans, positive behaviour support, risk management and medication management.

The provider had a safeguarding policy in place and all staff had completed training in relation to the prevention, detection and response to abuse. Staff spoken with were knowledgeable on what constituted abuse and what to do in the event of a concern or allegation.

The inspectors found that there were a number of compatibility issues evident among the resident group. For example, a resident was presenting with increased anxiety levels and behaviours of concern resulting in increased noise levels and some safeguarding concerns in the centre. This compatibility issue was impacting adversely on the quality and safety of care provided to other residents. This issue remained on-going at the time of this inspection.

Inspectors also found that the service had not managed some concerns in line with national policy to ensure that all incidents, concerns and allegations of abuse were reported, screened and investigated. The arrangements in place to manage a resident's finances required review as it was not evident that it was being appropriately monitored. In addition, it was unclear in one resident's file that the resident was supported to exercise control over their daily life for example, access to day services. Following the inspection, the inspectors requested assurances from the provider regarding safeguarding residents in the designated centre.

The inspectors reviewed a sample of residents' files and found that there was an up-to-date assessment of need in place. However, the assessment of need did not in all cases inform the care plans in place for each resident. This meant staff were not suitably guided in supporting the residents with their health and social care needs. For example, an assessment of need identified a number of needs for one resident including intimate care support and a health care need. However, no care plans were in place to guide staff in how this need was being managed. Staff spoken with were familiar with the needs of residents and the supports in place to meet those needs.

Inspectors reviewed a positive behaviour support plan in place for one resident. Despite the behaviour support plan being in place, the inspectors noted that there were significant numbers of incidents involving behaviours of distress occurring involving this resident on a frequent basis. These behaviours were found to impact on other residents availing of the services of the centre. The inspectors acknowledged that there had been intensive supports put in place to support this resident and observed a staff member implementing the positive behaviour support

guidelines during one interaction on the day of inspection. However, the positive behaviour support guidelines was found to be not fully effective in that the behaviours of distress were continuing to impact on others.

There were arrangements in place for the assessment, management and ongoing review of risk. The service maintained a risk register dated March 2018 which outlined individual and service risks and the controls in place to manage these risks. However, the risk register did not accurately identify and reflect all risks within the centre.

The previous inspection identified that some medication administration practices in the centre were not safe and increased the risk of potential medication errors in the centre. A recent medication audit carried out in November 2018 identified that medication errors were ongoing. The person in charge informed inspectors that some staff had received additional training and the centre was in the process of moving to a blister pack system in order to address medication errors. There were protocols in place for the administration of PRN (as required) medication. However, these required improvements to appropriately guide staff in the administration of PRN medications.

## Regulation 26: Risk management procedures

There were arrangements in place for the assessment, management and ongoing review of risk. The risk register did not accurately reflect the current risks within the centre.

Judgment: Substantially compliant

## Regulation 29: Medicines and pharmaceutical services

The practices in relation to medication required improvement to address the ongoing medication errors. The protocols in place for the administration of PRN (as required) medication required improvements to appropriately guide staff in the administration of these medications.

Judgment: Not compliant

## Regulation 5: Individual assessment and personal plan

There was an up-to-date assessment of need in place. However, the assessment of

need did not in all cases inform the care plans in place for each resident.

Judgment: Not compliant

## Regulation 7: Positive behavioural support

Inspectors reviewed a positive behaviour support plan in place for one resident. Despite the behaviour support plan being in place, the inspectors noted that there were significant numbers of incidents involving behaviours of distress occurring involving this resident on a frequent basis. These behaviours were found to impact on other residents availing of the services of the centre.

Judgment: Substantially compliant

## Regulation 8: Protection

There were some safeguarding measures in place in the centre, the service had a safeguarding policy in place and all staff had completed training in relation to the prevention, detection and response to abuse. However, not all concerns were managed in line with national policy to ensure that all incidents, concerns and allegations of abuse were reported, screened and investigated. In addition, the arrangements in place to manage a resident's finances required review as it was not evident that it was being appropriately monitored. Compatibility issues between the suitability of residents was also an ongoing issue which at the time of the inspection had not been resolved.

Judgment: Not 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 |
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| **Views of people who use the service** | |
| **Capacity and capability** | |
| Regulation 15: Staffing | Not compliant |
| Regulation 16: Training and staff development | Not compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 24: Admissions and contract for the provision of services | Not compliant |
| Regulation 31: Notification of incidents | Not compliant |
| Regulation 34: Complaints procedure | Not compliant |
| **Quality and safety** | |
| Regulation 26: Risk management procedures | Substantially compliant |
| Regulation 29: Medicines and pharmaceutical services | Not compliant |
| Regulation 5: Individual assessment and personal plan | Not compliant |
| Regulation 7: Positive behavioural support | Substantially compliant |
| Regulation 8: Protection | Not compliant |

# Compliance Plan for Grangemore Rise OSV-0002341

## Inspection ID: MON-0025570

## Date of inspection: 06/12/2018

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

This document is divided into two sections:

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

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

A finding of:

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

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

## Section 1

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

**Compliance plan provider's response:**

| **Regulation Heading** | **Judgment** |
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| Regulation 15: Staffing | Not Compliant |
| Outline how you are going to come into compliance with Regulation 15: Staffing:<br>• Recruitment has commenced to replace staff member who resigned their post on the 19th November<br>• The number of residents in the Designated Centre has been reduced in the short / medium term.<br>• The Designated Officer attended the staff meeting on the 14th December to offer support to staff.<br>• Principal Psychologist attended staff meeting on the 14th December to offer support for staff.<br>• In relation to current behaviours. The PIC and individual staff members have met with the psychologist on the 05/09/18, 19/10/18, 25/10/18 and 14/11/18.<br>• A full Multi Element Behaviour Assessment was completed on the 6th December - this is a supportive measure for staff and included education sessions in relation to medical issues of residents, issues and solutions around Behavioural challenges that arise in the centre.<br>• In the event of short notice absences regular relief / agency will be sourced in as far as possible<br>• The PIC has scheduled staff support meetings on the house roster. Staff will have the opportunity to raise concerns and issues at these meetings.<br>• Monthly data sheets are completed every 4 weeks and submitted to Service Manager for discussion at the support meetings, this process will ensure the effective communication of all concerns, actions and escalation if warranted. | |
| Regulation 16: Training and staff development | Not Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development: | |

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| • A full audit of all staff training has been competed on the 8th January 2019 (available in the centre for review)<br>• A training plan has been developed for 2019 for all staff in the centre.<br>• 2 staff have been identified to complete PBS training in 2019<br>• All outstanding staff requiring training in Therapeutic intervention Promoting Safety have completed training on the 21st January 2019 |

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| Regulation 23: Governance and management | Not Compliant |

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• The Organization has in place a procedure to ensure that the recruitment of staff is appropriate to the number and assessed needs of the residents in the designated centre.
• The recruitment of staff to fill the one vacancy has commenced 17/12/2018
• There is a clear management structure in place in the designated centre
• Monthly data sheets are completed every 4 weeks and submitted to Service Manager for discussion at the support meetings, this process will ensure the effective communication of all concerns, actions and escalation if warranted.
• Monthly meetings have been scheduled with Service Manager and PIC
• An annual review of quality & safety of the centre was completed for Jan - Dec 2017 and both residents and families were consulted in this process. 2018 annual review is currently being compelted.
• Two six monthly unannounced visits are completed annually for the centre. 26/02/2018 & 30/08/2018. A copy of these reports are available to residents and families.
• The PIC has scheduled staff support meetings on the house roster. Staff will have the opportunity to raise concerns and issues at these meetings .
• Clear auditing systems have been established to ensure effective service delivery and these are reviewed monthly by the PIC and the Service Manger to ensure effective comprehensive service delivery.
• A review of all safeguarding support plans has been completed incorporating discussion with residents.
• An accident and incident tracker has been developed to identify trends, appropriate actions and establish timeframes for redress.
• Management systems are now in place to ensure the service is safe and appropriate to residents needs, through consistent and effective monitoring and where needed escalated to senior management

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| Regulation 24: Admissions and contract for the provision of services | Not Compliant |

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:

• The organisation has a policy which details the admission procedure in detail.
• An extensive consultation process was compelted for one resident and all consultation meeting minutes are now in the residents file and have been communicated with staff

| Regulation 31: Notification of incidents | Not Compliant |
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Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• A full review of all incidents in the Designated Centre One was completed on the 7th December 2018
• One outstanding NF06 for an incident on the 31st August was submitted to the authority on the 7th December 2018
• The PIC will ensure that all required notifications will be sent to the authority in the required time frame.

| Regulation 34: Complaints procedure | Not Compliant |
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Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The registered provider has a complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.
• The complaints procedure is displayed in the centre in an accessible format.
• Residents are regularly reminded of the procedure at house meetings.
• The PIC ensures all staff follows the complaints policy and procedure.
• The PIC ensures each residents complaints and concerns are listened to and acted upon in a timely, supportive and effective manner.
• The PIC keeps a log of all complaints in the centre.
• The complainant receives regular updates on the progress of the complaint.
• Staff support residents to make complaints whenever they wish.
• All residents concerned will be provided with monthly updates from the PIC in relation to their complaints and actions completed to address it.

| Regulation 26: Risk management procedures | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The organisation has in place a risk management policy
• All staff are trained in the management of risk
• All risks will now be included on house Risk Register quarterly. Submission of Monthly data sheets to Service Manager will ensure appropriate risk escalation otherwise.

| Regulation 29: Medicines and pharmaceutical services | Not Compliant |
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Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• The Organization has a policy & procedure in place for the Safe administration of Medication, which is underpinned by national policy.
• This policy guide practices relating to the management of medication.... ordering/

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| receipt/ prescribing/ storing/disposal and administration of medication is in line with best practice.<br>• The Organisation ensure that all staff are provided with training in the safe administration of medication.<br>• NMOC attend staff meeting to discuss roles and responsibility for safe administration of medication on the 14th December 2018<br>• All Protocols in place for administration of PRN have been updated<br>• All nursing staff will complete the HSEland medication management training module |

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| Regulation 5: Individual assessment and personal plan | Not Compliant |

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| Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:<br>• All residents living in the designated centre have a comprehensive assessment of need which is reviewed annually or as required with multi disciplinary input as appropriate, this assessment allows for discussion around all aspects of their support needs.<br>• All residents personal plans outlining residents needs and supports in accordance with their wishes have been reviewed by 18th January 2019 and are now in place.<br>• An Personal Centered Plan audit is scheduled for February 2019<br>• All residents are involved in the person centered planning process and an annual wellbeing review meeting takes place with the involvement of MDT team as appropriate the resident is supported to attend this meeting. |

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| Regulation 7: Positive behavioural support | Substantially Compliant |

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| Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:<br>• The organization has a positive Behaviour Support Policy; the Positive Approaches Management Group (PBS steering group) has been set up to promote best practice used within the Organisation.<br>• Positive behaviour plans are in place for residents who require them<br>• Systems are currently in place to monitor / review and evaluate all PBS plans.<br>• The PBS plan is based on information supplied by the staff team to the Psychologist and is actively reviewed based on their observations, data recordings and reports- all of which is clearly documented in the service-user's file.<br>• Principal Psychologist attended staff meeting on the 14th December to offer support for staff.<br>• In relation to current behaviours the PIC and individual staff members have met with the psychologist on the 05/09/18, 19/10/18, 25/10/18 and 14/11/18.<br>• A full Multi Element Behaviour Assessment was completed on the 6th December -<br>• Ongoing Psychiatric and PBS reviews for residents are in place where required. |

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| Regulation 8: Protection | Not Compliant |

Outline how you are going to come into compliance with Regulation 8: Protection:
• St Michael's House Policy and procedure for the Protection of Adults from Abuse and Neglect is available in the designated centre.
• This policy is currently under review.
• All staff have received training in Safeguarding adults.
• The two staff that required refresher training in Safeguarding attended training on the 27th November 2018.
• All staff have completed online Children's First safeguarding training
• One outstanding NF06 for an incident on the 31st August was submitted to the authority on the 7th December 2018
• Going forward all notifications as required will be submitted to the authority in the required timeframe.
• All allegations of abuse will be reported and screened as per St Michael's house and National safeguarding policy.
• In relation to current behaviours, the PIC and individual staff members have met with the psychologist on the 05/09/18, 19/10/18, 25/10/18 and 14/11/18 and a full Multi Element Behaviour Assessment was completed on the 6th December
• Education sessions for staff were supported in relation behavioural challenges that arise in the centre.
• An ICM has been arranged for one resident on the 13th December and the safeguarding plan for this resident has been reviewed
• The Safeguarding plans for all residents have been reviewed with the Designated Officer on the 17th December 2018.
• Staff have received training in Positive Behaviour Supports.
• All Staff have received training in Therapeutic Intervention Promoting safety (TIPS)
• All incidents are reported on electronic forms and discussed at staff meetings.

## 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 |
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| Regulation 15(3) | The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis. | Not Compliant | Red | 31/01/2019 |
| Regulation 16(1)(a) | The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme. | Not Compliant | Orange | 08/01/2019 |
| Regulation 23(1)(c) | The registered provider shall ensure that management systems are in place in the designated centre | Not Compliant | Orange | 18/01/2019 |

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| | to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. | | | |
| Regulation 23(3)(b) | The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents. | Not Compliant | Orange | 18/01/2019 |
| Regulation 24(1)(a) | The registered provider shall ensure that each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose. | Not Compliant | Yellow | 18/01/2019 |
| 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. | Substantially Compliant | Yellow | 18/01/2019 |
| Regulation 29(4)(b) | The person in charge shall ensure that the | Not Compliant | Orange | 18/01/2019 |

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| | 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 to no other resident. | | | |
| 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 | 07/12/2018 |
| Regulation 34(2)(b) | The registered provider shall ensure that all complaints are investigated promptly. | Not Compliant | Orange | 18/01/2019 |
| Regulation 05(2) | The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as | Not Compliant | Orange | 28/02/2019 |

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| | assessed in accordance with paragraph (1). | | | |
| Regulation 07(1) | The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour. | Substantially Compliant | Yellow | 31/07/2019 |
| Regulation 08(2) | The registered provider shall protect residents from all forms of abuse. | Not Compliant | Red | 31/01/2019 |