Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of designated centre:	Kilbarrack
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Announced
Date of inspection:	02 May 2018
Centre ID:	OSV-0002358
Fieldwork ID:	MON-0021039

About the designated centre

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

Kilbarrack is a designated centre based in a North Dublin suburban area which supports five residents with intellectual disabilities. The designated centre is comprised of one single storey building with enclosed garden space to the rear. It contains an entrance hallway, six resident bedrooms, one staff sleep over room which contains an en-suite and also acts as a staff office, two sitting rooms, a generous kitchen and dining space, a large bathroom, and a smaller shower room with toilet facilities. The designated centre provides 24 hour residential supports to residents through a staff team of social care workers and a person in charge. The designated centre provides services to residents through a person centered, individualised and rights based approach and created a homely environment for residents to live.

The following information outlines some additional data on this centre.

Current registration end date:	31/08/2018
Number of residents on the date of inspection:	5

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
02 May 2018	10:15hrs to 19:00hrs	Thomas Hogan	Lead

Views of people who use the service

At the time of the inspection, five residents were availing of the services of this designated centre. The inspector met with all five residents and spoke in detail with three resident. Additionally, in assessing the quality of care and support provided to residents, the inspector spent time observing staff engagement and interactions with residents.

Four completed questionnaires were made available to the inspector, of which two were completed by residents and two were completed by family members. The questionnaires asked questions regarding a range of different topics including satisfaction with the service provided, food and mealtimes, visitors, personal rights, activities, care and support, the staff team, and complaints. A review of this information highlighted that there was a very high level of satisfaction by respondents across these areas.

Residents informed the inspector that they felt safe in the centre and had been informed of the process on how to make a complaint or voice a concern if they needed to. All residents expressed that they were satisfied living in the designated centre and spoke fondly of staff members from whom support was provided. The inspector found that residents were informed of their rights and entitlements and were consented with and supported to take an active role regarding the running of the designated centre.

Capacity and capability

The inspector found that overall, while high quality and effective services were provided to residents, some areas for improvement were identified which involved strengthening regulatory compliance. There were very clear examples of person centred and resident led practices on the day of inspection, however, the inspector found that some developments were required across three of the six regulations inspected against which related to *capacity and capability*.

The number, qualification and skill mix of staff members employed in the designated centre was found to be appropriate to number and assessed needs of residents, the statement of purpose and the size and layout of the centre. There were 6.0 full-time equivalent posts in the centre and, there was no vacancies at the time of inspection. A review of staff rosters demonstrated that the designated centre operated at the required staffing levels for the period of one month prior to inspection and there was evidence of a stable workforce. In addition, rosters were found to be flexible to support events important to residents. All interactions

between staff and residents were observed to have been timely, respectful and warm. Staff spoken with by the inspector were found to speak of residents in a positive, respectful and fond manner. All staff demonstrated comprehensive knowledge of the needs of each resident. A sample of four staff files were reviewed by the inspector and it was found that they contained all required information as set out in Schedule 2 of the regulations.

A review of staff training records found that all mandatory training courses, with the exception of first aid training and positive behavioural support training, were completed along with up-to-date refresher training for all staff members employed in the designated centre. One staff member had not completed training or refresher training in first aid, and two staff members had not completed training in positive behavioural supports. The service manager was aware of this matter and outlined a training plan in which these deficit was addressed through upcoming training in this area. The inspector found that while staff were appropriately supervised in both a formal and informal capacity in the designated centre, some one-to-one supervision meetings with staff were not completed as often as required by organisational policy on this matter. The person in charge was found to be based in the designated centre on a full-time basis, and, in their absence, there were named 'shift leaders' appointed and support was available from a service manager and an on call nursing manager if required.

An annual review of the quality of care and support had been completed and was made available to the inspector. In addition, a report of an unannounced visit carried out by a person nominated by the registered provider was available in the centre. The inspector found that arrangements were not in place for the performance management of staff members. The inspector found that the designated centre was appropriately resourced and that there was a clearly defined management structure in place. The person in charge of the designated centre was present on the day of inspection and demonstrated comprehensive knowledge of the needs of residents, appropriate knowledge of the regulations and legislative responsibilities, and good awareness of the strengths and weaknesses of the service. The person in charge informed the inspector that they had protected management time of eight hours per week. There was evidence available of internal auditing which examined areas such as health and safety, medication management, and transport vehicle checks.

A review of the statement of purpose in place in the designated centre (dated 22 February 2018) was found not to contain all required information as set out in Schedule 1 of the regulations. An opportunity was provided to the person in charge to review and update this document at the time of inspection and a revised document was made available to the inspector. The revised document (dated 03 May 2018) was found by the inspector to contain all required information.

The policies and procedure documents in place in the designated centre were reviewed by the inspector in the company of the person in charge. While the registered provider had previously communicated a plan with HIQA with regards to maintaining the policies and procedures outlined as required in Schedule 5 of the regulations, two required polices were found not to have been in place at the time

of inspection. These related to the recruitment, selection and vetting of staff members; and the management of personal property and possessions of residents.

Regulation 15: Staffing

The inspector found that the number, qualifications and skill mix of staff employed in the designated centre at the time of inspection was appropriate to the number and assessed needs of residents, statement of purpose and the size and layout of the designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

Some gaps were identified in staff training with one staff member requiring training in the area of first aid and two staff members requiring training in the are of positive behavioural supports. While there were formal arrangements in place for the supervision of staff members through one-to-one meetings with the person in charge, these were not completed as often as required by organisational policy.

Judgment: Substantially compliant

Regulation 22: Insurance

The registered provider had a policy of insurance in place which covered against injury to residents.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that arrangements for the performance management of staff were not in place in the designated centre.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

A revised statement of purpose was found to contain all required information as set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Judgment: Compliant

Regulation 4: Written policies and procedures

A policy was found not to be in place for the recruitment, selection and vetting of staff members, and the policy in place for the management of resident finances by staff did not provide direction on personal property and possessions of residents.

Judgment: Substantially compliant

Quality and safety

While the inspector found that the overall lived experience of residents availing of the services of the designated centre was positive, some areas of improvement were identified through the inspection process. Five of the eight regulations inspected against relating to *quality and safety* found areas of improvement were required to ensure compliance with the regulations was achieved. Despite this, the inspector found examples of good practice which included the involvement of residents in shaping the service received, the development of and maintenance of relationships with the local community and personal networks of residents, the promotion of development of communication skills through the use of assistive technologies, and the creation of opportunities for long term valued social roles to be developed.

The inspector found that there was a cultural focus placed on supporting residents with communication needs in the designated centre and staff members held shared values of developing the communication skills of residents. These shared values were evident throughout the designated centre and included the use of technology which had pre-recorded messages communicating the staff duty rosters to residents which acted as a source of reassurance. Another example included the use of an audio photo album which allowed for familiar voices to a resident provide assurances through recorded messages. The kitchen and dining area of the designated centre had easy read labels present on cupboards and drawers to support residents with their contents.

The inspector completed a full walk through of the designated centre in the company of the person in charge. The centre was found to have had an extension completed to the rear of the building circa 2003 and provided for considerable additional space for bedrooms, bathrooms and utility space. The centre had been designed and laid out to meet the aims and objectives of the service and the number and needs of residents. In addition, it was found to be very clean throughout, maintained to a good state of repair both internally and externally, accessible to all persons availing of services, and met the requirements set out in Schedule 6 of the regulations. Resident bedrooms were found to be decorated in accordance with the wishes, tasted and personal preferences.

There was a risk management policy in place in the designated centre which was found to meet the requirements of the regulations. In addition, a risk register was maintained which listed 19 individual risks present in the designated centre. While the inspector found that presenting risks were appropriately identified, no risks which were listed on the register contained any additional control measures. This included two risks which were rated as 'medium'. A review of incident, accident and near miss records maintained in the designated centre found that a total of 15 incidents had been recorded as having occurred in a 12 month period up to 30 April 2018. The inspector found that the follow up to six of these incidents was not appropriate or sufficently comprehensive.

For the most part the inspector found that there were arrangements in place to safeguard residents. The inspector found that all staff members had completed training in the area of safeguarding and protection. All staff members spoke with by the inspector demonstrated sufficient knowledge of what constituted abuse and what action to take in response to witnessing, suspecting or an incident of abuse being reported to them. All three residents with whom the inspector spoke with about abuse stated that they felt safe living in the designated centre and were aware of how to report abuse or any concerns that they may have. All residents were found to have intimate care support plans in place for the provision of intimate care and there was an organisational policy in place relating to this matter also.

Measures in place to support residents with behavioural needs were formalised in positive behavioural support plans and these were found to be individualised, comprehensive and unambiguous in their guidance for the reader. Behaviours of distress were identified with accompanying proactive strategies listed. In addition, strategies for escalating, reactive, and recovery periods were provided. Staff members spoken with demonstrated awareness of the contents of these plans and the inspector observed practices in place at the time of the inspection which was outlined in the plans. There were no restrictive practices in place in the centre at the time of inspection and the person in charge communicated that this unrestricted environment formed part of the designated centre's values.

The inspector reviewed fire precautions in the designated centre and found that a fire safety policy and internal emergency response plan were in place. In addition, there were emergency response protocols in place for a range of scenarios including power outages, and loss of water and heating. Records were available to demonstrate daily and monthly checks of escape routes, fire alarm system,

emergency lighting, and fire fighting equipment. There were fire containment measures in place at key points throughout the building and easy read fire evacuation procedures were on display. Service records demonstrated that both the fire alarm system and emergency lighting in place were serviced and maintained on a regular basis. A review of individual personal emergency evacuation plans in place for residents found that these documents were reflective of the support needs of residents in the event of an emergency situation. Two of the four emergency exits in place in the designated centre did not have emergency lighting in place to ensure that the egress route in the event of a fire would be illuminated.

A sample of resident files were reviewed by the inspector and it was found that while there were comprehensive assessments of need completed for each resident, these were not completed on at least an annual basis. The inspector found that there were personal plans in place for all identified needs of residents, however, in some instances these plans did not provide sufficient direction or guidance for staff on how to support residents with the identified needs. In addition, there was an absence of evidence to demonstrate that the personal plans in place were reviewed on at least an annual basis for their effectiveness, or that there was inputs from allied health professionals in any review process of plans. This matter was brought to the attention of the person in charge and the service manager and explained in detail.

The inspector reviewed medication management practices in the designated centre and found that all medication contained in the medication cabinet was within the listed expiry dates. Keys for this cabinet were found not to have been stored in a securer manner, however. The person in charge provided immediate assurances on this matter. A review of prescriptions and medication administration records for a sample of residents found that medication had been recorded as having been administered to residents as prescribed. Staff administering medications had completed specific training in the area and, when speaking with the inspector, demonstrated awareness of the appropriate actions to take in the event of a medication error. The designated centre used a 'blister pack' system for administering medications, and PRN medications (medications taken as the need arises) were managed in a standard container manner. A review of PRN medication guidelines in place found that protocols were not signed by a prescribing practitioner. In addition, the person in charge confirmed that capacity and risk assessments were not completed for residents regarding the self-administration of medication.

Regulation 10: Communication

The inspector found that there was a considerable focus placed on supporting residents to develop communication skills in the designated centre and this was enhanced through the use of assistive technology.

Judgment: Compliant

Regulation 17: Premises

The premises of the designated centre were found to be designed and laid out to meet the aims and objectives of the service and the numbers and needs of residents.

Judgment: Compliant

Regulation 26: Risk management procedures

The management of risk in the designated centre was found not to be satisfactory. There was an absence of 'additional control' measures for all 19 risks identified on the centre's risk register, despite two risks being rated as 'medium'. In some cases, the follow up to incidents which occurred in the designated centre was found not to be appropriate.

For example, in the cases of the medication errors, the staff member involved was not required to complete refresher training or further assessments.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Two of the four emergency exits in the designated centre were found not to have had emergency lighting in place.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The inspector found that keys for the medication cabinet were not stored in a secure manner. Capacity and risk assessments had not been completed for residents with regards to the self-administration of medication. PRN protocols were not signed by a prescribing practitioner.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspector found that the assessment of need and personal planning processes in place in the designated centre were not satisfactory and required development. Assessments of need were not completed on at least an annual basis and plans viewed by the inspector did not provide clear guidance to the reader on how residents should be supported. In addition, personal plans were not reviewed for their effectiveness.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The positive behavioural supports in place in the designated centre were found to be satisfactory with support plans clearly identifying behavioural support needs and providing unambiguous guidance for the reader on how to appropriately manage behaviours of distress.

Judgment: Compliant

Regulation 8: Protection

Two incidents were found to have occurred in the designated centre in the time sine the last inspection which met the definitions of abuse as per the *Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures (HSE, 2014)* document. The inspector found that neither incident had been appropriately managed in accordance with the aforementioned policy.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Kilbarrack OSV-0002358

Inspection ID: MON-0021039

Date of inspection: 02/05/2018

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The register provider provides training including refresher training for all staff which is appropriate to their position. • The PIC of the designated centre has organized training on the next available training for staff in the following area PBS. • First Aid training for remaining staff member completed the 21/05/18	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The designated centre will continue to be resourced to ensure all residents support needs are met. • There is a clear management structure in place in the designated centre • There are management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. • An annual review of quality & safety of the centre was completed for Jan - Dec 2017 and both service and families were consulted in this process	

- Two six monthly unannounced visits are completed annually for the centre. A copy of these reports are available to residents and families.

- Supervision training has been rolled out across the organization. The PIC of the designated centre has completed this training the 29/05/2018

- Supervision meetings between the PIC and staff will be held at least four times throughout the year. These meetings will provide an opportunity for staff to rise any concerns about the quality and safety of care and support provided to residents. Staff also have an opportunity to discuss any issues or concerns they may have

Regulation 4: Written policies and procedures	Substantially Compliant

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

- The registered provider has prepared and implemented policies and procedures as set out in Schedule 5 of the regulations. All policies and procedures as appropriate are in line with and under pinned by HSE policies and procedures.

- All the policies and procedures referred to in schedule 5 are now available to all staff in the designated centre.

- In March 2018 the registered provider reviewed all schedule 5, policies and procedures, that are in place. The registered provider will ensure to continue to review all schedule 5 policies and procedures every 3 years and where required these will be reviewed and updated in accordance with best practice.

- The organisation currently adopts the HSE Vetting Policy in line with the National Vetting Bureau (Children and Vulnerable Persons) Acts 2012 to 2016, and are now fully compliant in this regard.

Regulation 26: Risk management procedures	Substantially Compliant

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

- There is a Risk Management policy is place. St Michaels House are updating the Risk Management Policy to reflect changes in assessment of risk including methodology, updating of risk assessment template and risk register template to ensure that significant risks are sufficiently managed, tracked and reviewed for effectiveness. Revised policy will be brought at Quality Safety Executive Committee for approval July 2018

- The PIC is trained in the management of risk and will continue to develop systems

in the centre for the assessment, management and ongoing review of risk, which include a system for responding to emergencies.

- A review of all designated centre risks and proportionate risk allocation, with additional controls added will be completed by 31/07/18

- The organization will ensure that all staff receive training in the safe administration of medication.

Regulation 28: Fire precautions	Substantially Compliant

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

- The register provider will ensure that effective fire safety management systems are in place so that there are adequate precautions against the risk of fire in the designated centre.

- The register provider in consultation with the organisation Fire Officer will ensure that adequate levels of emergency lighting are in place.

- The organization's Fire Safety Officer completed a fire safety report 15/11/17. The PIC ensures that the action plan from this is completed.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

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.

- There is a system of recording for each resident of prescribed and administered medication and these are kept in a secure location within the designated centre.

- All PRN guidelines in the designated centre prescribed on a residents medication administration sheet (MAS) has been reviewed and is now supported by administration guidelines and signed by the relevant practitioner

- Capacity and risk assessment are now completed for all residents in regard to self administration of medication.

- The organization will ensure that all staff receive training in the safe administration of medication.

- The person in charge shall ensure that any medicines kept in the centre is stored securely

- The person in charge shall ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed. The person in charge will follow the organization policy Safe Administration of Medication if any medication errors occur.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

- The PIC will continue the review of all residents personal plans within the designated centre to assess the effectiveness of each plan.
- Within this review the personal plan will be evaluated to ensure the plan was developed arising from the residents goals and wishes.
- Each resident living in the designated centre has comprehensive assessment of need, this is reviewed annually or as required with multi disciplinary input as appropriate.
- An assessable format of each residents personal plan is now available to each resident and where appropriate their representative in a format that is meaningful to the individual.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

- The organization has a policy in place for the Protection of Adults from Abuse and Neglect this reflective of National Safeguarding Vulnerable Persons at Risk of Abuse Policy.
- Each resident is supported to develop skills so that they have knowledge and skills to promote their personal self care and protection.
- Where there are any incidents, allegations or suspicion of abuse , the PIC will ensure this is reported to the Designated Officer and notifications are made to the authority.
- Safeguarding training for all staff has been completed.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/10/2018
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/05/2018
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional	Substantially Compliant	Yellow	30/05/2018

	responsibility for the quality and safety of the services that they are delivering.			
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	31/07/2018
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	31/10/2018
Regulation 29(4)(a)	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 any medicine that is kept in the designated centre is stored securely.	Substantially Compliant	Yellow	03/05/2018
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate	Substantially Compliant	Yellow	03/05/2018

	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 29(5)	The person in charge shall ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability.	Substantially Compliant	Yellow	30/05/2018
Regulation 04(1)	The registered provider shall prepare in writing and adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	03/05/2018
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an	Not Compliant	Orange	31/05/2018

	appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Not Compliant	Orange	31/05/2018
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Not Compliant	Orange	30/06/2018
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a	Not Compliant	Orange	31/07/2018

	review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	10/05/2018
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Substantially Compliant	Yellow	10/5/2018