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)

Name of designated centre:	Nuncio Apartment Complex
Name of provider:	S O S Kilkenny Company Limited by Guarantee
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	05 June 2019
Centre ID:	OSV-0003411
Fieldwork ID:	MON-0023936

About the designated centre

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

This centre aims to provide community based living in a home from home environment and is registered for 11 adults. It is an apartment complex on the outskirts of a large town and consists of eight individual two bedroom apartments. One of the apartments is communal and used as a base by staff, in addition to being a space where residents could meet and socialise together as they wished. In accordance with the statement of purpose the centre aims to develop services that are individualised, rights based and empowering; person centered, flexible and accountable. This centre strives to provide a service for residents that is in and of the community where they live.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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
05 June 2019	09:00hrs to 17:00hrs	Tanya Brady	Lead

Views of people who use the service

There are eight residents living in this centre, however, two were on holidays the day of inspection. The inspector had the chance to meet and spend time with five individuals over the course of the day. This centre is an apartment complex where two residents share one apartment and the other six live individually. There is a communal apartment where residents were seen to spend time during the day either with each other or with staff, in addition to spending time with the centres pet dog.

One resident who lives individually requires a more supportive environment and staff remain in their apartment at all times and they do not freely access the communal apartment. This resident was not present on the day of inspection, however, the inspector from review of the environment and documentation could see that the resident did not have the same independent living experience as other residents.

One resident came to the communal apartment to have a cup of tea in the morning and told the inspector that they were looking forward to going to their choir later in the day and demonstrated a favourite song. This resident also loved to write letters and when the inspector was invited into their apartment a specific room had been laid out as an office. This was where the resident liked to sit and write. Their fridge was also covered with postcards and magnets from holidays and gifts from others that corresponded with the resident. The resident was being supported by a staff member to style their hair in preparation for going out.

Another resident proudly showed the inspector their history research project which was framed and hung in the hallway of their apartment. This resident was attending an event in a local historical centre that afternoon and was looking forward to meeting others with an interest in history. They were planning a new project on a local landmark building. The inspector was shown a travel brochure and the resident discussed their plans for a holiday to Disney World Paris and who they had asked to travel with them.

In another apartment the resident was keen for the inspector to see their fish tank and explained that the local pet shop had taught them how much to feed the fish and how to clean out the tank. This resident also had multiple bird feeders outside the window of the apartment and had positioned their kitchen table so they could watch the birds. The staff were seen to encourage this resident to take the dog for a short walk later in the afternoon and also in giving them photocopied information on events happening in the community that they thought the resident might enjoy.

There was a shared garden space to the rear of the apartment complex and many of the residents had individual raised beds, or small sheds for their personal use. There were events or parties that had been held at the centre as a way of getting to know neighbours and this had resulted in some swapping of plants for the garden.

In addition there were plans for other events and for the establishment of a 'Sunday roast' tradition in the communal apartment.

Capacity and capability

In reviewing the capacity and capability of this designated centre the inspector had concerns relating to the local governance as not being delivered to the necessary standard.

On the day of inspection there was not a suitably qualified and experienced person in charge found to be in place. The registered provider notified the Health Information Quality Authority (HIQA) on 23 April 2019 that a person in charge was in post but this was not found to be the case on the day of this unannounced inspection. It became clear the centre had been operating without a person in charge for twelve weeks and HIQA had not been notified of this as required by Regulations. Additionally, the registered provider did not have a clear idea of when a person in charge would be in place. The absence of a person in charge was found to be having an adverse impact on the quality of care and safety of residents. There was an acting team leader for one aspect of the service, supported when possible by the assistant director of services. In addition, there was a programme team leader with a second staff team supporting a single resident in the centre. There was no person in charge and two distinct teams operating without effective governance or sufficient oversight.

The registered provider had carried out an annual review of service provision following which an action plan had been developed and the areas identified had been followed through by the previous person in charge. In addition six monthly unannounced reviews of the quality and safety of care were taking place, and the team leader was seen to be working on some of the actions identified as outcomes from these. There were a number of provider led audits reviewing areas such as 'health and safety' and 'complaints' that had been completed over the previous year. Staff meetings are taking place on a monthly basis with the acting team leader and the programme team leader supporting each other in the management of these. The inspector reviewed the minutes of the previous two meetings and it was seen that incomplete minutes had been filed for staff to read as both team leader and programme team leader had taken minutes. These were amended on the day of the visit.

There was a core group of consistent staff employed to support the residents with one resident having a specific team in place providing 24 hour support from within their apartment. The other residents had allocated hours based on assessed needs. One resident also required support on a 24 hour basis and at night the single staff member on duty slept in the communal apartment and could be available to other residents if required. From a review of a sample of personnel files the inspector

found that recruitment procedures were satisfactory with the required documents and checks being completed. The inspector reviewed both actual and planned rotas there were two separate rotas for the individuals in the apartments and the resident with their own team and were an accurate reflection of the staffing on the day within the apartments.

On review of the staff training audit and discussion with the team leader it became apparent that two staff members had not been included on the audit list. This was identified on the day of inspection and their training records also reviewed. All staff had received training and refreshers in line with resident's needs with one staff member attending training that day. Staff had been in receipt of formal supervision by the previous person in charge. The acting team leader had attended recent training on the providers supervision systems and was due to begin supervising staff on their team. The other team in the centre was not under their remit. The team leader and the programme team leader were both supervised by the assistant director of services.

Regulation 14: Persons in charge

The appointed person in charge was not in post for this centre.

Judgment: Not compliant

Regulation 15: Staffing

The registered provider had ensured that the number, qualification and skill mix of staff was appropriate to the assessed needs of residents. Additional staff had recently been appointed to provide a service specific to an individual resident as required.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector found that staff had the required competencies to manage and deliver person-centred support for residents. They had access to training and refreshers in line with residents' needs although the staff record system in the centre required amending to include all staff. The arrangements for formal supervision were changing as staff would be in receipt supervision provided via two separate team

leaders .

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspector found that there were governance and management structures in place. However, due to the absence of a person in charge and two distinct teams operating under a single centre it was difficult to ensure consistent and effective monitoring of care and support for residents. There was an annual review of care and support and six monthly visits by the provider with evidence of follow up on actions from these reviews.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector found that residents lived in comfortable and relaxed homes. It was apparent that residents' quality of life was prioritised and managed in a person-centred manner with emphasis on the residents' choices and preferences evident. Their social care needs were actively promoted and encouraged and they accessed numerous external activities such as choir, arts and crafts or gardening clubs in addition to their local communities and holidays away. There was also an emphasis on supporting residents with life-skills including money management and looking after their own home, which the inspector saw that they took pride and ownership in.

Within individual apartments and in communal areas there were areas in need of maintenance and repair such as filling of plaster cracks or minor holes as well as painting however these had been self-identified by the registered provider and there were requests logged for these works to be carried out. Two residents were hoping to swap apartments and there had been a number of supported discussions with each of them in advance of making a final decision. It was reported that these apartments would be prioritised for redecoration.

The inspector reviewed a number of residents' personal plans and found them to be person-centred. The registered provider following an internal audit had acknowledged that the setting of goals had previously not been reflective of residents' current needs or wishes. This matter was seen to have been raised for discussion during staff meetings. Each resident plan reviewed by the inspector was seen to have completed a personal outcome workbook meeting with updated goals following that discussion with residents. However, while improvement was apparent

there were still gaps in documentation and in updating information. For one resident the weekly activities and goals set in 2018 were still fixed on their fridge, while another resident had the goal of purchasing a new household item achieved five months earlier but the goal was still active.

Residents were encouraged to understand and manage their own healthcare needs as appropriate and had access to pertinent health and social care professionals as required. The healthcare team within the organisation was also seen to work alongside the staff team in supporting residents. Staff were seen to support residents as required, to implement specialist healthcare recommendations such as insulin injections for diabetes management.

The inspector found that the provider was promoting a positive approach to responding to behaviours that challenge. Residents' positive behaviour support plans clearly guided staff practice in supporting residents to manage their behaviour and they were reviewed in line with psychology or psychiatry reviews. Staff who spoke with the inspector were knowledgeable in relation to residents' behaviour support needs in line with their positive behaviour support plans. The inspector found that there were restrictive practices on the day of inspection such as keypad locks on an apartment door for one resident and there were discussions on the day with respect to decisions taken but not documented to limit one resident to set numbers of cigarettes per day.

The inspector was not satisfied that all systems for the protection of vulnerable adults were sufficiently robust and that all residents in this centre were appropriately safeguarded. Some residents, while accessing the community independently, were involved in a number of significant incidents that required An Garda Síochána involvement. The providers oversight, management and response to these incidents was inadequate. A protocol for community access was undated and a safeguarding plan for one resident regarding independent access to the community was dated March 2018, and had not been updated or reviewed following incidents. As a result appropriate safeguarding plans were not implemented to prevent incident re-occurrence and to appropriately safeguard residents.

The registered provider had implemented new systems with respect to the management of resident finances following an action identified in a recent six monthly unannounced audit. These were seen to be detailed, including updated capacity assessments and clear protocols for money management in resident files. If residents required support with personal or intimate care, then plans were seen to be in place, however some of these were not signed and discussions with the resident regarding these not clearly documented. For other residents who did not require support they had signed clear documents acknowledging discussion had occurred and the outcome of same.

There were suitable arrangements to detect, contain and extinguish fires in the centre. Suitable equipment was available and there was evidence that it maintained and regularly serviced. Each resident had a personal emergency evacuation procedure. Residents upstairs were clear in explaining to the inspector the protocol around not using the lift and accessible guidelines were displayed in the lift. Fire

procedures were available in an accessible format and on display. Staff had completed fire training and fire drills were occurring. Actions from fire drills were reviewed and recent drills had highlighted concerns with respect to residents remaining in the centre with the dog. The assistant director of services was engaged in discussions on the management of this.

There were procedures in relation to medicines management and suitable practices in relation ordering, receipt, storage, and disposal of medicines. All residents had been involved in capacity assessments for the management of medicines and individuals received support as assessed. Staff spoken to were clear on the process to follow should a medication error occur.

There was a risk register in the centre which was detailed and included clinical and environmental risks with relevant plans and control measures outlined. However not all risks present in the centre had been identified, one such was the use of restrictive practices, and another the presence of the dog in the centre. Changes in residents assessed needs were not always promptly responded to. For example, one resident had not had risks updated in over fifteen months despite changing needs. Residents had personal alarms in the event of a fall or needing staff urgently or could use their phones to call for help; there was a call alarm in the main hallway to alert staff in the communal apartment at night as it may be locked.

Regulation 17: Premises

Overall, the inspector found that the physical environment was clean and residents lived in personalised and inviting spaces. However, there were a number of areas in need of maintenance and repair as outlined in the body of the report.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The registered provider had a risk register in place within the centre. Not all risks present in the centre had been identified on the register and some individual risks had not been updated to reflect changing needs.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Systems were in place for the prevention and detection of fire. Regular checks were carried out by staff and equipment was regularly serviced by certified personnel. Evacuations drills were implemented and actions arising from the outcomes if drills was apparent.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

There were appropriate policies, procedures and practices relating to the ordering, receipt, prescribing, storage and disposal of medicines. Audits were completed regularly.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Personal plans were found to be person-centred. However, improvement was required with regard to documenting all residents' goals and to ensuring information was consistent across all documentation.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had appropriate assessments completed and were given appropriate support to enjoy best possible health. Residents' changing needs were recognised and appropriate assessments and supports put in place. Residents had access relevant health and social care professionals in line with their assessed needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider promoted a positive approach in responding to behaviours that challenge. Residents had positive behaviour support plans which clearly guided staff to support them to manage their behaviour. Staff who spoke with the inspector

were found to have the up-to-date knowledge and skills to support residents to manage their behaviour.

Judgment: Compliant

Regulation 8: Protection

The registered provider had systems in place for the protection of vulnerable adults however the inspector did not feel that they were sufficiently robust. In particular the inspector was not assured that such incidents as outlined in the body of the report, were given due consideration to adequately protect the residents from re-occurrence and to sufficiently protect them from abusive interactions in the community.

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
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Nuncio Apartment Complex OSV-0003411

Inspection ID: MON-0023936

Date of inspection: 05/06/2019

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and 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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: Person In Charge now in place since 17/6/19.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff are now listed on the training audits for the Nuncio apartment's complex. The staff training officer also completed an updated staff training audit for the location on 2.07.2019. Staff supervision will take place for all staff using the Quality Conversation Policy. The PIC will oversee this process to ensure all staff will receive supervision in a timely and consistent fashion in line with the policy guidelines.	
Regulation 23: Governance and	Substantially Compliant

management	
Outline how you are going to come into compliance with Regulation 23: Governance and management: A revised "meeting minutes" protocol has been written to ensure that information is recorded in a clear manner and all detail is communicated to the staff teams. The PIC will review the communication process with the programme leaders and the ADOS and agree a process to ensure consistent and effective monitoring of care and support for residents is in place. Person In Charge in place since 17/6/19. PIC assisted by 2 Social Care Leaders in the governance and management of the center. PIC will relinquish her PIC role in another designated center (OSV 0003413) as soon as the new PIC for that center is registered. NF30 for the new PIC (OSV 0003413 will be submitted this week (w/c 8/7/19).	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The areas requiring maintenance have been listed for works already and some maintenance work has already been completed. The work requiring completion in apartments 5 and 6 has been completed and the residents have moved in. (Residents were swapping apartments) Previously scheduled work on fire doors has been listed for 8.07.2019 and 9.07.2019.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: A review of the centre risk register has been completed and all risks not listed on the risk register are now present. A full review of all risk assessments for all residents is currently underway in the centre to ensure all are reflective the current needs of all residents. There are specific reviews underway also for two specific residents who use their local community independently. A meeting was held on 26.06.2019 with one of the residents to fully review his risk assessments for using the community. A revised protocol is now in place as well as supporting documentation from the resident outlining how important spending time in the community and his connections with other people, is to him.	

Refresher training on risk management and completion of risk assessments has taken place with the staff team in Nuncio and also on 5.07.2019 a full team meeting was dedicated to addressing concerns on managing risk while ensuring safety and respecting the wishes of the residents. This was facilitated by the ADOS and the team leader in the location.
The staff training officer and chair of the Human Rights committee also met with some of the staff who have particular concerns in managing risk while ensuring the rights of the residents are respected at all times.

Training on the use of restrictive practices has taken place for all team leaders and this has been discussed at the recent team meeting. This is also on the agenda for the next team meeting w/c 15.07.2019.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
All individual personal plans for each resident are currently under review and all are now using the new Workbook to clearly reflect the current wishes of the resident. Goal setting and evidencing of work towards achievement of same were also discussed with each keyworker. All out of date information has been removed.

A workshop session has been planned for all staff to attend in August with the PIC and ADOS to review personal plans. Date to be confirmed by 22.07.2019 due to annual leave.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The residents have all been assisted to understand the need for self care and protection in the community in particular those who are actively independent. The team leader and the staff team have actively engaged with the residents in the areas of safeguarding and protection and the use of the HSE easy read guidelines on safeguarding has been used.

All safeguarding plans for residents are currently under review and in consultation with the residents and other relevant people as required to support the resident to make appropriate choices and decisions, amendments and changes will be addressed as required. One particular resident has a recently agreed formal safeguarding plan from the HSE following an incident in his community.

Contact has been made with the local Sports Partnership to source "Safety in the Community" training for all residents.
The community Gardai are due to contact the team leader mid July regarding a visit to the complex to discuss safety and the importance of self care and protection. Some of the residents are known by the Gardai already and they have stated that they often make contact with the residents in town, on an informal basis just to check in.

One particular resident has been referred again to a psychologist for further review of capacity and also for advice on how to support the resident, in particular when there are concerns from a mental health perspective. The protocol for this resident using his community independently, in particular at night has been re written and a second protocol has been written to support the resident when mood is low and he is unresponsive to normal communication.
Informal contact with local pubs has also been made and the social worker is due to meet the resident again to also discuss safety in the community.
A general safeguarding plan is currently being drawn up in consultation with the resident and a new general " safety protocol " is in place now for this resident with clear guidelines for staff supporting the resident and in particular when they need to contact the on call manager.

Contact has been made with Sage, the independent advocacy service to advice on any training available on decision making, advocacy and self care and awareness and also on ensuring the residents' wishes are respected.

As noted above training on restrictive practice has taken place with the team leaders and ongoing discussion with both the quality officer and the human rights committee chair will assist the team in supporting the resident using their local community in as safe a manner as possible.

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 14(1)	The registered provider shall appoint a person in charge of the designated centre.	Not Compliant	Orange	17/06/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/08/2019
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	31/08/2019
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in	Substantially Compliant	Yellow	31/08/2019

	accordance with the statement of purpose.			
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Substantially Compliant	Yellow	17/06/2019
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	09/07/2019
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Substantially Compliant	Yellow	31/07/2019

Regulation 05(7)(a)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include any proposed changes to the personal plan.	Substantially Compliant	Yellow	31/07/2019
Regulation 05(7)(b)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the rationale for any such proposed changes.	Substantially Compliant	Yellow	31/07/2019
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Substantially Compliant	Yellow	31/07/2019
Regulation 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.	Not Compliant	Orange	31/07/2019
Regulation 08(2)	The registered provider shall	Not Compliant	Orange	31/07/2019

	protect residents from all forms of abuse.			
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.	Not Compliant	Orange	31/07/2019