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:	Cumas New Ross
Name of provider:	Cumas New Ross
Address of centre:	Wexford
Type of inspection:	Unannounced
Date of inspection:	19 June 2018
Centre ID:	OSV-0004739
Fieldwork ID:	MON-0021904

About the designated centre

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

The service provides long-term residential care for up to 11 residents, and one respite care bed for both male and female residents who have a primary diagnosis of mild to moderate intellectual disability with low support needs. The statement of purpose also states that residents must be independently mobile.The residents who avail of the respite bed attend the services day facilities and therefore the residents are familiar with each other. The centre comprises two houses some distance from each other in a coastal town. One house is a bungalow and the second house is two story. All residents have their own bedrooms and the premises are comfortable and suitable to meet the current needs of the residents. There are suitable safe gardens and the centre is within ease of access to all local facilities, services and the community.

The following information outlines some additional data on this centre.

Current registration end date:	10/11/2019
Number of residents on the date of inspection:	11

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
19 June 2018	09:30hrs to 19:30hrs	Noelene Dowling	Lead

Views of people who use the service

The inspector met five and spoke with three residents during the course of the inspection. The residents told the inspector how they were supported by the staff, really enjoyed their activities, were helped to make decisions and had access to lots of external facilities. They stated they could come and go as they wished and they were supported ot have a meaningful full life. They said they had great holidays, which they were saving up for.

Capacity and capability

There were governance structures and reporting mechanisms in place to oversee and direct the quality and safety of care for the residents. There was a commitment evident to consultation with residents and families at all levels about their wishes and care needs.

However, currently the structures for oversight and direction of practice were not fully effective and operating in a cohesive manner to ensure the overall wellbeing and monitoring of the residents care.

This is demonstrated by some of the findings in the quality and safety section of this report. This included the implementation of suitable support plans and effective implementation of polices and risk management procedures. In addition, adequate evidenced based assessment, oversight and supports for resident's behaviour and mental health needs was not available.

While some of the actions from the previous inspection had been implemented, a number had not. Additional findings from this inspection are similar and reflect the lack of a governance and management structure which supported residents to have a safe, quality care provided to them.

Quality management systems were in place however, no satisfactory auditing systems were implemented. This resulted in a lack of ability to ensure incidents or accidents or behaviours were adequately assessed and could be used to inform changes to practices or identify trends which may affect the residents overall wellbeing.

Unannounced inspections and an annual review had been undertaken. However, these did not identify any actions and did not demonstrate a robust review of the quality of the service, systems for improvement, transparency, or ongoing development of the service.

There were sufficient resources available and staffing arrangements were suitable in terms of the numbers and care needs of residents currently. The centres statement of purpose is very clear in its requirement that residents have a level of capacity and

remain independently mobile and the centres single staffing arrangements were based on this.

However, the resident's age profile and care needs are changing. At the time of the inspection, one person was in the process of being discharged to an older person facility and was already resident there being discharged from an acute care facility. . Ill health was a factor and the provider stated that they did not have the capacity to provide the care required.while the inspector was informed that this was the residents own wish and an advocate was sourced. The records in relation to the multidisciplinary decision-making in relation to this serious long-term move were very poor. Regardless of this , however, the option to remain in the centre with additional supports was not available to the resident. Given the age of the other residents this matter requires consideration in terms of the long-term duty of care and strategic planning for the service and the residents.

While recruitment procedures were robust, there were again deficits in training including fire safety training although this was scheduled to be completed. No formal safeguarding training had been undertaken with staff although the person in charge advised that she had informed staff of the requirements. They had received medication management, first aid and management of potential and actual aggression training. Staff also had professional qualifications.

There were supervision and induction systems in place and these were seen to be satisfactory. However, the house coordinators were not supervised and a significant responsibility for oversight and direction of care rested with this post holders. This lack of supervision did not ensure residents received appropriate care and that best practice was adhered ot at all times.

Staff were observed to be engaging well and were supportive of residents who appeared every comfortable with them. However, there was a lack of clarity and knowledge evident in terms of residents more complex care needs evident.

The inspector was informed that any complaints had been made by residents or relatives were addressed as they occurred. However,no details were maintained of any such discussions which would ensure that any issue was resolved. Residents told the inspector that they could tell staff and managers about any concerns they may have and they felt comfortable raising concerns.

Systems for consistently notifying HIQA regarding any adverse incidents also required review, as a number of incidents seen by inspectors had not been reported.

During the last inspection the provider was required to devise a number of policies, the provider had taken action to address this however, the inspector found that residents records were not maintained in a manner to ensure consistency of care or management of important information.

Regulation 14: Persons in charge

The person in charge was suitably qualified and experienced for the post.

Judgment: Compliant

Regulation 15: Staffing

The staffing numbers and skill mix are currently suitable but this should be kept under review.

Recruitment practices were robust.

Judgment: Compliant

Regulation 16: Training and staff development

While staff had appropriate training there were deficits noted in fire safety and safeguarding training .

Supervision for staff was regular and of good quality but house co-ordinations did not have this support.

Judgment: Substantially compliant

Regulation 21: Records

Residents records were not complete and did not fully identify their assessed needs or supports.

Judgment: Substantially compliant

Regulation 23: Governance and management

While there were systems in place for oversight of the centre these went fully effective to bring about improvements despite the commitment evident.

Systems for reviewing the quality and safety of care were not robust and there was no strategy for the development of the service and the changing needs of the

residents.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose was in accordance with the regulations and care arrangements were in accordance with this statement.

Judgment: Compliant

Regulation 31: Notification of incidents

Not all of the required notifications had been forwarded to HIQA as required.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

While residents could express concerns and these were managed in a timely manner there were no records maintained of any concerns raised.

Judgment: Substantially compliant

Quality and safety

The inspector found that the residents had a good quality of life with meaningful activities, day services and practices which supported and promoted independence. The provider ensured that they were supported to achieve their personal aims and goals. These included supported employment, skill development (including pottery making), life skills and self-care.

They had choices regarding their routines in the centre including meals and activities and at the time of the inspection a number were on holidays and others were planning to do so.

Annual reviews of their care and quality of life were held which were attended by the residents themselves if they wished and the relatives. They also had regular

meetings with identified key workers, which ensured their voices were heard and their goals achieved. There was evidence of an emphasis on consultation with residents. They were supported to maintain good health and had access to a number of relevant clinicians.

Not withstanding this however, the quality and safety of residents care was potentially impacted on by a number of factors primarily connected with direction and oversight of practices, adherence to support plans and adequate assessment and guidance for staff in the management of behaviours of concern or underlying mental health conditions.

There was no evidence based behaviour support plans implemented where these may have been required. Of more concern was the inconsistent and individualised response of staff noted in both daily records and incident reports to some behaviours presented. This was not based on assessment, guidance or clarity with regard to the underlying causes or meaning of the behaviours. There was psychiatric support available but these assessments were not used to inform staff and support the residents.

While actions in relation to the adequate monitoring of residents weights required following the previous inspection had been undertaken there were insufficient support plans devised. For example, in relation to the need to ensure residents food was of the correct consistency to prevent a choking episode. There was also a lack of clarity regarding a referral for a speech and language assessment, which had been indicated.

In general, there was a lack of clarity and detail available both from the records reviewed and from speaking with staff to ensure that residents more complex needs were known and suitably responded to. This could pose a potential risk to residents long-term wellbeing. In addition while there were systems in place for ensuring that the staff had updated information on health and well being for the respite residents. there was no comprehensive information/report available where a resident was transferred to another facility. This posed a risk to any resident moving from the centre in that pertinent information regarding their care would not transfer with them.

Risk management procedures also required review. The risk register was not adequate and there were no satisfactory systems for identifying, assessing and managing risks to the residents either clinically or in the environment.

While some incidents such as falls were reviewed and resulted in a revised assessment an overall review of incidents and risk rating was not consistent practice. The inspector was informed that all incidents were reviewed and discussed at the team or coordinator meetings. However, the records seen did not consistently support this.

The actions in relation to safe medicines management procedures required following the last inspection had in the main being addressed. However, the reporting of and management of medicines errors was not satisfactory. The inspector saw a record in a daily log, which detailed that a blister pack of medicines prescribed for a resident

was not intact, several days medicines were missing from the packaging and it had been roughly resealed.

This had not been reviewed to ascertain what precisely had occurred ot the medicines and why and if there had been a risk to the resident.

The management of PRN (administered as required medicines) in particular sedatives also required review. While these were prescribed and protocols were in place the inspector saw a record where such a medicine had been given and symptoms presented indicated that the time the medicines were administered was not the correct time to do so. There was no procedure for staff to seek guidance on this before administering such medicine.

Safeguarding systems were satisfactory and the there were trained designated persons in the centre. The inspector was informed that no such incidents were being managed at the time of the inspection.

While the premises are currently suitable for the residents, there was again a higher standard of decor in one residential unit than the other. Although some works had been done since the previous inspection with new furnishings and an additional sun room in one unit.

Fire safety systems had been improved since the previous inspection with containment doors installed in all relevant areas. Fire alarms and equipment had been serviced as required.

In one unit, it was noted that while emergency lighting was installed it did no cover a significant area used for evacuation via the kitchen and another room that could impede the process. Residents had individual evacuation plans and regular drills were held at various times with any difficulties noted. The residents told the inspector about these and were familiar with the process in place to evacuate the premises should there be an emergency.

These findings indicate that the changes to the oversight systems required as outlined under capacity are crucial to ensure adequate oversight and direction of practices in a timely manner.

Regulation 10: Communication

Residents were supported to communicate, visual aids were used and staff were familiar with sign language.

Judgment: Compliant

Regulation 13: General welfare and development

Residents preference for work, training and life skill development were encouraged and supported.

Judgment: Compliant

Regulation 17: Premises

The premises are suitable for the current needs of the residents but this should be kept under review as needs change..

One unit requires some decoration in terms of paint work.

Judgment: Substantially compliant

Regulation 25: Temporary absence, transition and discharge of residents

There was no satisfactory system for ensuring that adequate and comprehensive information was made available to other services where residents were being discharged.

The inspector was not assured that a discharge being undertaken was being managed in accordance with the residents wishes, best interests and full consultation.

Judgment: Not compliant

Regulation 26: Risk management procedures

Systems for identifying risks, responding to and learning from incidents were not sufficiently robust to protect residents and prevent recurrences.

Judgment: Not compliant

Regulation 28: Fire precautions

There were suitable fire safety managements system in place equipment was serviced as required. However, one unit did not have emergency lighting in one

evacuation area and all staff did not have fire training although this was scheduled.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

There was a lack of oversight of medicines management systems/review of errors and administration of PRN medication.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents social care and health care needs were very well supported. However, they did not have support plans to guide staff for some issues and not all needs had been assessed.

Judgment: Not compliant

Regulation 6: Health care

Residents had good access to health care professionals.

Judgment: Compliant

Regulation 7: Positive behavioural support

Systems for assessing and responding to behaviours of concern and mental health conditions were not satisfactory.

Judgment: Not compliant

Regulation 8: Protection

Policy and system for reporting and responding to concerns in regard to

residents were in place.

There was good oversight of residents finances.

Judgment: Compliant

Regulation 9: Residents' rights

Systems for upholding and supporting residents rights were evident.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 25: Temporary absence, transition and discharge of residents	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Cumas New Ross OSV-0004739

Inspection ID: MON-0021904

Date of inspection: 19/06/2018

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: Safeguarding Training was held on the 31st of July with 6 of the 9 Residential staff attending. The remaining 3 staff who were on shift and/or annual leave will attend Safeguarding Training week commencing 3rd September. Fire Safety Training was held on the 1st August with 6 of the 8 Residential staff requiring the training this year attending. Some were not due their refresher for a number of months but were completed at this time. The remaining 2 staff will be attending the training on the 6th September. Co-ordinators are met with on a monthly basis to ensure consistency of approach across the designated centre. Monthly supervision meetings to be held on the second Thursday with Co-ordinators will commence in September.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: All Care Plans are currently being reviewed as part of the annual review process with completion due by 31st August. This will include all requirements i.e. assessed needs and supports. As part of this process the Care Plans are being inputted electronically in the houses to enable changes to be made more effectively and in a timely manner.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: There are regular Co-Ordinators meetings at which improvements to the service are discussed, the decision makers for the service attend these meetings and agree any	

action required. Updates are given on both staff and individuals and any changing needs identified and plans made for same.

There is an Operations and Development Team Meeting held every 8 weeks in which every aspect of the service, including residential, is reviewed and development of the service is discussed and planned.

A robust discharge system for higher needs will be developed by 30th September 2018.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

The notifications in question were the quarterly notification spreadsheet forms. These have now been diarized. All were nil returns.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

The organization was unable to produce records for complaints that did not exist. Individuals have house meetings, PCP meetings, both a Residential Facilitator and Day Facilitator and were updated on the complaints procedure at the Individuals Day Meeting on the 27th March with easy to read documentation. When a concern is raised by an individual it is dealt with immediately so that it does not become a complaint. All concerns raised will now be included in the person's daily record. This will be communicated to all staff at the residential staff meeting on 29th August 2018.
The system of having both a Residential and Day Facilitator enables the individual to express their concerns to a person who is not directly involved in the respective area if they wish i.e. if they have a concern in relation to their residential service they can talk to their Day Facilitator and vice versa.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

Paint colours have been chosen by the residents and the paintwork is being scheduled for September.

Changing needs are being reviewed on a regular basis but this service is a low support service and should the needs of the residents become high support then alternative arrangements will be sought in conjunction with expressed wish of the individual in line with every other Irish Citizen.

Regulation 25: Temporary absence, transition and discharge of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence, transition and discharge of residents:

A more robust transfer and discharge policy will be implemented in line with best practice by 30th September 2018.

Regulation 26: Risk management procedures	Not Compliant

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

A meeting was held on the 14th August to review incident and risk management procedures and to determine how to bring the procedures in line with the recently published HSE Incident Management Framework, including the After Action Review. We are also reviewing a software system that will automate the process and ensure that we are compliant. The new forms will be designed by August 31st, an overview of the software has been arranged for August 28th with a trial scheduled for October 2018 and full implementation by year end.

Regulation 28: Fire precautions	Substantially Compliant

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

Emergency lighting identified as needed in one evacuation area was installed on 1st August.

Fire Safety Training was held on the 1st August with 6 of the 8 Residential staff requiring the training this year attending. Some were not due their refresher for a number of months but were completed at this time. The remaining 2 staff will be attending the training on the 6th September.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

Please see attached scanned document in relation to current practices in place.

A refresher of Cumas' Medications Management Policy was held with all Residential Staff on 7th August 2018

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:

Care Plans are currently being reviewed as part of the annual review process that is in place. This will be complete by August 31st for all individuals. As part of this process the Care Plans are being inputted electronically to enable changing needs to be updated

effectively and in a timely manner.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

Mental Health 1st Aid Training was carried out on the 7th August.
MAPA training was carried out on the 5th & 6th July with a second session carried out on the 10th & 11th July.
Safeguarding Training was completed on the 31st July with further training schedule for w/c 3rd September.
Report writing was determined to be an issue and that training was completed on 14th August.
There are behavior support plans that have been developed in consultation with multi-element support and in line with the "Supporting People With Behaviours That Challenge Including Self-Harm Policy". Health Facilitator will review these plans and the policy with all residential staff to ensure consistency of approach by the end of September.

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.	Not Compliant	Orange	07/09/18
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	13/09/18
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	30/09/18
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	31/08/18
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is	Not Compliant	Orange	30/09/18

	safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	30/09/18
Regulation 25(1)	The person in charge shall ensure that, where a resident is temporarily absent from the designated centre, relevant information about the resident is provided to the person taking responsibility for the care, support and wellbeing of the resident at the receiving designated centre, hospital or other place.	Substantially Compliant	Yellow	30/09/18
Regulation 25(4)(d)	The person in charge shall ensure that the discharge of a resident from the designated centre is discussed, planned for and agreed with the resident and, where appropriate, with the resident's representative.	Not Compliant	Orange	30/09/18
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and	Not Compliant	Orange	21/12/18

	ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	16/08/18
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.	Not Compliant	Orange	06/09/18
Regulation 29(4)(c)	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 out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.	Not Compliant	Orange	16/08/18
Regulation	The person in charge	Substantially	Yellow	16/08/18

31(3)(a)	shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Compliant		
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	29/08/18
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an 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.	Not Compliant	Orange	31/08/18
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre,	Not Compliant	Orange	31/08/18

	prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).			
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Not Compliant	Orange	16/08/18
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Orange	30/09/18