Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Killybegs
Name of provider:	Talbot Care Unlimited Company
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	02 March 2023
Centre ID:	OSV-0008351
Fieldwork ID:	MON-0038131

About the designated centre

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

Killybegs provides a residential service for adults both male and female over the age of 18 years with intellectual disabilities, autistic spectrum and/or acquired brain injuries who may also have mental health difficulties and behaviours of concern. The objective of the service is to promote independence and to maximise quality of life with support by a team of social care staff members, with access to community nursing resources as required. The designated centre consists of a bungalow house just outside of a town in County Kildare.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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 (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
Thursday 2 March 2023	11:00hrs to 18:30hrs	Gearoid Harrahill	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet with all three current residents, and review their commentary on the service attained through key worker sessions and satisfaction surveys. The inspector also observed support and interactions from the front-line support team, and read guidance available to staff to progress each resident's personal objectives and routines. Overall the inspector found that residents were safe and appropriately cared for by a committed, friendly and supportive social care team. However some development was required to structure plans for meaningful opportunities in work, life skills, community involvement and recreational activities in line with identified needs and resident wishes.

This was the first inspection of this designated centre since residents had moved in at the end of 2022. Residents commented that they had settled in well, got along with their housemates, and spoke highly of their support team. Residents were supported by three staff during the day and two waking staff at night, and had access to vehicles belonging to the house to access the community. The provider evidenced action being taken to get more staff licensed and insured to drive to optimise this access. For each resident, the provider had followed their admission plan which included giving people the opportunity to visit the house and local area and meet the other residents, before confirming they were happy to live in the house. Due to the progressing needs of one resident, it was identified the service was no longer suitable for their requirements and evidence was present that they had identified more appropriate accommodation, and discussed this transition with the resident who understood and was happy with the plan.

Residents indicated they were generally satisfied living in this house and knew to whom they would speak if anything was bothering them. In commentary made in satisfaction surveys and key working sessions, residents commented positively about the staff team and said they got along with their housemates. While residents commented that sometimes there was a communication barrier between themselves and the staff, the inspector observed friendly and social chat between staff and residents and how quality of interactions was being monitored by the person in charge through performance enhancement sessions.

Residents commented that they wished to get back into the working world, to travel the country more and attend GAA matches. The assessment of support needs also indicated the need to develop plans to support residents to gain new employment opportunities and develop social relationships and independent living skills. In the sample reviewed, the inspector observed that plans had not yet been developed to attain these life enhancement goals with specific, measurable and time bound objectives. None of the residents were engaged in employment, education or social schemes. However, staff commented that in spite of the lack of formal plans they were working to support the residents to cook and use appliances.

Some improvement was required to provide evidence of meaningful social

excursions, as many of the entries noted that the resident "went for a drive with staff" as their day's activity with no notes on where they went or what they did. When the inspector compared these entries against daily records for the house, some of these drives were related to attending medical appointments or collecting prescriptions, rather than social or recreational activities. Some residents stated in their keyworker sessions that some days could be boring for them and they felt stuck in a routine, and the inspector observed that residents spent much of the afternoon in bed. Residents were also noted to be asleep during the day in other centre records such as fire drills. The inspector observed some examples of resident social activities with staff, including photos of a day trip, and one resident who went to watch rugby training. Overall, however, there was limited evidence available of ongoing activities planned or recorded to indicate how residents were supported and encouraged by the team as a whole to pursue meaningful interests and activities in the house and community, in accordance with their assessments, wishes and discussions with their key worker.

Residents were supported to decorate and personalise their bedrooms in line with their preferences. While the house was not fully occupied at the time of inspection, the person in charge was making arrangements to ensure that the house allowed for sufficient storage of belongings and accommodation of visitors when the house was fully occupied, without impacting on the use of the private and communal areas by others.

The inspector observed a culture of positive risk taking and respect for the assessed independence levels of residents. While originally introduced as a precaution for new residents during the settling-in period, the provider had already identified where certain risks were not present and features such as a door code-locked from the inside or restricted access to sharp items could be reduced or removed. Independence with medicine and personal care was also being kept under review during the initial months of accommodation. The provider was in the process of working with financial institutions to create accounts for the residents to securely lodge their money, and to be assured that all resident income was accounted for.

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

Capacity and capability

The inspector observed examples of robust governance arrangements in place to effectively manage this new designated centre and support front-line staff members. The management arrangements in place were suitable for this centre and the service was sufficiently resourced for the number and support profile of residents.

This centre was first registered in October 2022 and the local management and staff

team consisted entirely of personnel recruited from other service providers or through an international recruitment campaign. The person in charge was suitably qualified and experienced in leading residential support settings. The inspector was provided evidence to indicate how they were supporting their staff to develop their professional and interpersonal skills on this new team. Performance management objectives were identified through probation and supervision minutes, which included examples of delegated ownership of responsibilities. Service objectives were also discussed in team meetings, including topics such as getting staff insured on service vehicles to optimise community access, and ensuring that progress notes towards measurable quality improvement objectives were appropriately recorded. The inspector observed staff engaging in a friendly and patient manner with residents, and demonstrating a good knowledge of their personalities and interests. Staff commented that they felt supported by both their colleagues and line manager to carry out their duties. Arrangements for deputation of the person in charge and contacts for out-of-hours management support were in place.

The person in charge had conducted a number of audits in the service in subjects such as infection control practices and management of restrictive practices, and where areas for standards development were identified, timely enhancement objectives were set out and discussed with the team. A number of regulatory deficits noted by the inspector had also been identified by the person in charge, and some minor matters such as document reviews identified were addressed during this inspection.

The provider had followed their admissions policy during the transition of residents into the centre, including ensuring that the service, skill-mix and clinical support available was suitable for their assessed needs. In an instance in which it was determined that the centre was no longer ideal to support resident needs, timely action was being taken to arrange new accommodation in consultation with the multidisciplinary team and the resident.

Regulation 14: Persons in charge

The person in charge was suitably qualified and experienced in leadership and management roles in residential care settings, and was knowledgeable of their role and responsibilities under the regulations.

Judgment: Compliant

Regulation 15: Staffing

The centre was staffed with sufficient personnel to provide support for the number and assessed support needs of residents. Planned and actual rosters were clear in

identifying the names, roles and shift patterns of management and front-line personnel in the centre. The inspector reviewed a sample of personnel files which contained required documentation under Schedule 2 of the regulations.

Judgment: Compliant

Regulation 19: Directory of residents

The provider maintained a directory list of residents with information and contacts details required under the regulations.

Judgment: Compliant

Regulation 21: Records

Documentation and records required during this inspection were readily available for the staff to access and provide for review.

Judgment: Compliant

Regulation 22: Insurance

The provider had appropriate insurance arrangements in place for this service.

Judgment: Compliant

Regulation 23: Governance and management

The inspector was provided evidence to indicate the auditing and quality improvement systems for this designated centre. The management had conducted audits in the centre including infection prevention and control, review of restrictive practices and assessment of support needs, with evidence of how the findings of these audits were communicated to the staff team.

The inspector observed evidence of staff members being subject to supervision in accordance with provider policy, and a schedule of meetings for probation and routine performance management was established. The inspector reviewed a sample of these meetings which discussed meaningful topics to the skills and

competencies of staff, including objectives for the team to work on, such as ensuring that complete records were being kept on resident supports, and making progress on attaining driving licences to optimise resident activation outside the house.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

The inspector reviewed transition planning records for this newly registered service and found an appropriate record of how the provider was assured that each resident was happy to live in this centre and that the centre resources were sufficient to meet their needs. Signed contracts were in place setting out terms and conditions of residency between the provider and resident.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider had composed their statement of purpose for the designated centre, including information required under Schedule 1 of the regulations.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider had developed a suite of policies and procedures as required under Schedule 5 of the regulations which was readily accessible in the designated centre.

Judgment: Compliant

Quality and safety

In the main, the inspector found evidence that residents were supported in a service which promoted positive risk taking, restraint-free living space and choice-led routines. However, a number of areas were still in their infancy regarding structured, measurable goals around life enhancement opportunities. Requirements

for planning objectives, staff support guidance and risk assessments and controls had been identified in audits checks and assessments of need, however there was a lack of evidence that action had been taken to address these findings.

The inspector reviewed a sample of assessments of the personal, social and health care needs of residents done on their admission to the service. Personal plans developed from these were written in person-centric manner, and were relevant to the dependence levels of residents, particularly regarding activities of daily living and personal care. A number of the support needs identified in the admission assessment did not have associated staff guidance and resident support plans created.

Residents had appropriate space in which to personalise their bedrooms and store their belongings. The provider kept an inventory of valuables belonging to residents. Staff advised the inspector that work was being done to support residents to open and use financial accounts in their name, for the provider and resident to be able to see and fully account for money belonging to each person.

The staff were knowledgeable in the purpose of residents' medicines, and how to record their use. Staff maintained complete and signed records of administration times and had appropriate guidance on precautions and maximum doses. Medicines on the controlled drugs register had appropriate security and auditing measures which staff followed diligently. Some medicines requiring refrigeration were stored in the food fridge, which was not in line with good practice.

The premises was clean and in a good state of repair, with staff following appropriate hand hygiene opportunities and use of face coverings in line with current national guidance for residential care services. Staff had appropriate guidance available to them on appropriate handling of food, waste, cleaning materials and precautions related to residents with active infection and colonisation risk.

The premises was equipped with fire-rated doors, smoke seals and self-closing mechanisms to facilitate effective containment of fire and smoke. The alarm system, emergency lighting and fire-fighting equipment was all in working order and serviced regularly. Drills took place in the service to test staff practice in the event of emergency. However, a risk causing substantial delay had been identified during a drill, the action for which was develop protocol for future reference and measure staff knowledge of this. This had not been completed and assurance could not be provided that staff would what to do in response to this risk. Before the end of this inspection the provider committed to ensuring these risk control protocols were developed and their effectiveness assessed.

Residents were supported in an environment which utilised a low amount of environmental restriction. Restrictions in place such as risk items being locked away, or doors being code-locked from the inside, were introduced as a precaution while residents were new and risk was being assessed. The person in charge had already identified where these practices could be reduced or retired where no associated risk existed.

Regulation 12: Personal possessions

The inspector reviewed a sample of residents' financial arrangements. Not all residents had access to an account in a financial institution in their name.

Financial support goals and associated plans identified as required through the assessment of needs had not been developed.

Judgment: Substantially compliant

Regulation 17: Premises

The premises of the designated centre was suitable in size and layout to meet the support needs of the residents, the house was clean and in a good state of repair.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents had access to a variety of meal options as well as drinks and snacks. The staff were provided guidance on supporting residents with assessed needs related to healthy eating or weight management.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

For a resident for whom the provider had determined that the designated centre could no longer effectively support their needs, the inspector found evidence to indicate that a more suitable service had been identified and that the resident was being consulted about the transition.

Judgment: Compliant

Regulation 26: Risk management procedures

Some risk management assessments and control measures had not been developed where assessed on admission, or updated following incidents or recommendations from relevant healthcare professionals.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Staff were observed following appropriate infection prevention and control procedures in the centre. The inspector observed front-line staff using suitable precautions in the management of cleaning materials, environmental hygiene, waste management, food safety, and supporting residents with risk related to healthcare associated infection. Staff were observed using face coverings and gloves in line with good practice and disposing of the latter appropriately between tasks. Flushing of seldom-used outlets and drains was included in routine household tasks, to mitigate the risk of waterborne bacteria in areas not yet used by residents.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had identified a risk during a fire drill which had the potential to cause substantial delay to a safe and prompt evacuation, and had resulted in practice evacuations ending without being assured that everyone could safely and promptly exit the building. While the emergency plan was updated to identify this high-rated risk, the procedure to follow in response to this risk had not been developed and the scenario had not been practiced since, per the provider's action plan. As such, staff did not know when asked what they would do to ensure their own and a resident's safety in the event of this delay occurring during an emergency evacuation.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Some medicines requiring refrigeration were observed being stored in the kitchen fridge with the food, which was not in accordance with best practice. However overall, arrangements and staff knowledge on practices for the recording, administration, labelling and disposal of medicines were appropriate.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed a sample of the support plans for the personal, social and health care needs of residents following an assessment of needs carried out on admission. A number of the residents' assessed needs had not had a corresponding support plan developed to guide staff on supporting these needs. These included but were not limited to supports related to: behavioural presentations, money budgeting, epilepsy care, employment goals and life skills. Some of the personal plans referred the reader to supplementary guidance which had not yet been created, or had not been updated to reflect the recommendations of allied health professionals following appointments and reviews.

There was limited evidence in personal plans outlining supports required to maximise the residents' personal development in accordance with their wishes. Evidence in keyworker notes and resident surveys indicated that residents wished to be involved in more social and employment opportunities, however there were no personal development goals active to guide staff and measure progress in these objectives. Improvement was required to evidence where residents had availed of meaningful social engagements, as a number of journeys related to healthcare appointments were logged as recreational excursions.

Judgment: Not compliant

Regulation 6: Health care

The inspector found evidence to indicate that residents were supported to attend a general practitioner (GP) of their choice, and that access to appropriate healthcare professional such as the community nurse, psychiatrist, behavioural specialist or occupational therapist was facilitated in accordance with their assessed support needs.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant

Compliance Plan for Killybegs OSV-0008351

Inspection ID: MON-0038131

Date of inspection: 02/03/2023

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 12: Personal possessions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: The Person in Charge (PIC) has undertaken a further review of all residents' financial assessments and individual financial support plans. A review of resident's onsite finances has been completed by the Chief Operations Officer, with no discrepancies noted. The PIC will continue to review and reconcile statements, ensuring all financial transactions are transparent. All financial assessments currently in place have been reviewed to ensure they reflect each resident's individual level of support. This will ensure residents money management plans continue to be robust and reflective of the resident's support requirements.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: This is a new centre. At the time of inspection there were 3 residents residing in the centre ranging from periods of 3 to 4 months pre inspection. The Person in Charge (PIC) has undertaken a review of each resident's pre admission assessment of need. The purpose of this review was to ensure that all identified areas of support identified at pre- admission have a corresponding support plan or risk assessment. Any additional needs identified post admission will be reflected in residents personal plans and risk assessments as required.	

All risk assessments devised will detail appropriate control measures. Risk assessments will be reviewed at least annually, or more frequently if required. The review of these risk assessments will be cognisant of the risk assessments in place in terms of managing any ongoing risk.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: The Person in Charge had completed 4 fire drills in advance of the inspection. Unfortunately, on one occasion a resident failed to evacuate the centre.

The PIC carried out an unannounced evacuation of the Centre on the 3rd of March following the fire alarm being triggered. The resident who had previously refused to leave the Centre during a fire drill, safely evacuated without any delays and with staff support went directly to the fire assembly point.

Key working sessions have been completed with this resident regarding fire safety and the safe evacuations of the building.

Fire safety and fire drills is a standing agenda item during resident meetings, and it is explained to all residents the necessity to engage with fire evacuations. This is to ensure that staff and residents can safely evacuate the premises at all times.

Pic implemented protocol in the event a resident refuses to exit the centre when there is a fire. This protocol includes the following measures. All staff will be trained in the implementation of this protocol when completing their induction into Killybegs.
• Each resident has an individual Peeps, should an issue be identified when carrying out scheduled fire drills implement the following measures.
• Communicate that the drill is in fact smoke detection and not a scheduled fire drill.
• Use proactive strategies, offering tea/coffee or something of interest to the resident to encourage them to leave the building. (This will be specific to each resident based on our knowledge of their individual preferences, and clearly identified in detail within their Personal emergency evacuation plan)
• If during an actual fire any resident declines to leave the Centre which is unlikely staff to utilise supported walk to physically support resident to Egress Killybegs house safely to the designated assembly point.

A further planned fire drill took place on the 25.03.2023 with all residents. All residents safely evacuated the Centre without delay and in line with their personal evacuation plans.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
On the day of inspection, the medication fridge in place required review, to ensure the temperature control was appropriate. A medication fridge with an appropriate lock was purchased and installed in the centre on the 3rd of March. This ensures that any medication that requires refrigeration is securely stored at the appropriate temperature.

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 has undertaken a review of all support plans for each resident. The PIC has ensured all identified support needs documented on admission have a corresponding support plan in place to guide staff practice.

All support plans and associated guidance documents are reviewed in line with Talbot Group policies.. The EpicCare system flags when documentation including support plans require updating/review or re assessing.

The PIC has provided in house training to the entire staff team of support workers regarding maximizing each residents personal development and the recording of this through key working, goal planning and updating the personal plan to reflect these outcomes.

PIC provided training and education to the staff team in the area of developing weekly planners that include community inclusion, opportunities to access new prospects and develop relationships in the wider community.

In collaboration with each resident, the PIC & Keyworker have identified SMART goals, that are outcome based and in line with their personal preferences.

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Substantially Compliant	Yellow	30/04/2023
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	31/03/2023
Regulation 28(3)(d)	The registered provider shall make adequate	Not Compliant	Orange	10/03/2023

	arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.			
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	31/03/2023
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	03/03/2023
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal	Not Compliant	Orange	31/03/2023

	plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).			
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	31/03/2023