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:	Portlaoise Area 2
Name of provider:	Health Service Executive
Address of centre:	Laois
Type of inspection:	Unannounced
Date of inspection:	14 September 2022
Centre ID:	OSV-0002488
Fieldwork ID:	MON-0037913

About the designated centre

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

Portlaoise Area 2 is a designated centre operated by the Health Service Executive. The centre provides residential care for up to nine male and female residents, who are over the age of 18 years and who have an intellectual disability. The centre comprises of two houses, located a few kilometres from each other. Residents have their own bedrooms and access to bathrooms, sitting rooms, utilities, kitchen and dining areas and to garden spaces. Residents have access to a range of local amenities such as shops, churches, restaurants, pubs, leisure facilities and barbers. The staff team comprise of a mix of staff nurses and care assistants, who are on duty both day and night to support residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

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
Wednesday 14 September 2022	10:10hrs to 16:35hrs	Anne Marie Byrne	Lead

What residents told us and what inspectors observed

Although this designated centre comprised of two houses, for the purpose of this inspection, only one of these houses was visited by the inspector. Upon the inspector's arrival, she was greeted by a member of staff, who performed temperature checking and hand sanitizer was available in the main hallway for the inspector to use, prior to entry. The person in charge later attended the centre to facilitate the inspection. Over the course of this inspection, a number of good practices were observed; however, significant improvements were identified to various aspects of this service, and these will be discussed further in the subsequent sections of this report.

Five residents lived in the house that was visited by the inspector and they were supported by a consistent staff team, comprising of nursing and care staff. These residents primarily required care and support in terms of their social care, personal care, with some requiring positive behavioural support. There was a very calm and relaxed atmosphere in the centre, with staff supporting residents with their morning routines. Over the course of this inspection, the inspector had the opportunity to meet with some of these residents, some of whom spoke briefly with the inspector about activities that they liked to engage in. One resident, who was relaxing in the sitting room, told the inspector that they had attended a music concert in a nearby hotel the previous weekend and really enjoyed it. Another resident, who sat with the inspector while she reviewed some documentation, told of how they were looking forward to going to their workshop the following day and showed the inspector some craft work that they were working on. The inspector observed residents to move freely around their home and appeared very comfortable in the company of the staff members who were on duty. Staff interacted with consideration for, and kindness towards the residents and spoke respectfully with the inspector about each individual resident's preference for how they wished to spend their recreational time.

There was a sense of homeliness to this centre, which was clean, comfortable, tastefully decorated and had many photographs of the residents engaging in various activities, proudly displayed in communal areas. Each resident had their own bedroom, which was decorated to their own personal taste and each bedroom displayed an activity board, outlining the planned activities for that particular resident. Residents also had shared access to bathrooms, two sitting rooms, a kitchen and dining area, utility and also to a large front and rear garden space. In response to the communication needs of some residents, along with the aforementioned activity schedules in residents' bedrooms, picture boards were also used in the kitchen, displaying images of the planned menu for the week. A cabin-like structure was also available in the back garden for residents to use, where some enjoyed playing board games, while others liked go out there to concentrate on their art work.

The adequacy of this centre's staffing and transport arrangements had a positive impact on the quality of social care delivered to these residents. These residents had

lived together for a number of years, got on very well together and sometimes engaged in activities as a group, while other times, liked to engage in them independent of their peers. During the inspection, residents went out and about in the community to go for a walk with the support of staff, which the inspector was told, was something that these residents often liked to do. Staff who met with the inspector also told of how these residents regularly enjoyed availing of gym and jacuzzi facilities in a nearby hotel, liked to use a nearby snoozlen room, often had meals out, liked to attend music concerts and enjoyed having a drink when at such events. Some residents had also been on overnight stays with staff, which the inspector was informed, was something that these residents had really enjoyed. Along with social activities, much effort was made by staff to ensure these residents were very involved in the running of their home. Residents' team meeting were regularly held to gather residents' preferences for activities and meal planning, and residents were also encouraged to participate in household tasks such as watering plants, laundry duties and also helped with taking out the bins.

Although these residents enjoyed a good quality of life and had sufficient resources available to them to support their assessed social care needs, there was a number of improvements required to ensure the quality and safety of service that they received was effectively monitored and overseen. This will now be discussed in the next two sections of this report.

Capacity and capability

This was an unannounced inspection following receipt of information by the Chief Inspector of Social Services, relating to concerns with regards to residents' intimate care, staffing and also in relation to the arrangements in place to support the quality and safety of care delivered to residents in this centre. Although good practices were observed over the course of this inspection, significant improvements were identified with regards to risk management, safeguarding arrangements and also with regards to the oversight and monitoring systems, to ensure these were effective in overseeing specific aspects of the quality and safety of care delivered to residents. In addition, this inspection also identified where some improvement was also required to aspects of positive behavioural support and personal planning.

A consistent staff team was in place in this centre and of the staff who met with the inspector, they demonstrated good knowledge of each resident's assessed needs and of their role in supporting them. This was a nurse-led service, whereby, nursing support was available to all residents during the day and night. Arrangements were in place, should the service require additional staffing resources, which included the use of agency staff, from time-to-time, who were familiar with the centre and with the assessed needs of the residents who lived there. A sample of rosters reviewed by the inspector, clearly demonstrated that where additional staff support was required in the weeks prior to this inspection, the provider had ensured consistent

agency staff were only rostered to the service.

Over the course of this inspection, it was identified that a number of incidents that were occurring, were not being reported through the centre's incident reporting system. Some of these incidents were with regards to changes identified to residents' skin integrity, and the non-reporting of these was not in line with the provider's own policy and procedure. In addition to this, following discussion with the person in charge, it was also identified that a further incident which had occurred relating to the intimate care of one resident, had also not been reported. The failure to adequately report this incident, impacted the provider' ability to ensure that this incident was reviewed to establish if there was any safeguarding concern or breach to the rights and dignity of the resident involved. Furthermore, the failure of this incident to be appropriately reviewed also impacted on ensuring that the provider put appropriate oversight and monitoring measures in place to ensure a similar incident did not re-occur in this centre. Because of this deficit in the reporting of incidents, this also further impacted the provider's ability to clearly demonstrate that all incidents were being reported to the Chief Inspector, in line with the requirements of the regulations.

Six monthly provider-led visits were occurring in this centre and the most recent report reviewed by the inspector did identify where some improvements were required. However, although the provider had this monitoring system in place, it required further review as it was ineffective in identifying the specific issues found upon this inspection with regards to safeguarding, risk management, personal planning and behavioural support, to allow for them to be satisfactorily addressed.

Regulation 15: Staffing

This centre's staffing arrangement was subject to regular review to ensure residents had the staff support that they required in accordance with their assessed needs. Nursing support was provided to residents both day and night and the provider also had adequate out-of-hours arrangements in place to support staff during such hours. Arrangements were in place, should the service require additional staffing resources, which included the use of regular agency staff, who were familiar with the centre and with the assessed needs of the residents who lived there.

Judgment: Compliant

Regulation 23: Governance and management

The provider had ensured this centre was adequately resourced in terms of equipment, staff and transport and internal communication systems were in place, which allowed for staff and management to regularly discuss any concerns regarding

residents' care and welfare. However, significant improvements were required to this centre's oversight arrangements to ensure that where incidents were occurring, these were appropriately reported, reviewed and investigated, as and when required, to ensure appropriate action was taken in response to these incidents. For example, following the failure of local management to report an incident involving the intimate care of a resident, this resulted in no further action being taken to determine any safeguarding concern or breach of this particular resident's rights.

Although the provider had monitoring systems in place, these required review to ensure their overall effectiveness in identifying where specific improvements were required within this centre. For example, even though the provider had recently completed a six-monthly provider-led visit of this centre, this was ineffective in identifying the specific improvements required within this centre, which were identified upon this inspection.

Judgment: Not compliant

Regulation 31: Notification of incidents

Improvements were required to the oversight of incidents occurring at this centre to ensure all incidents were notified, as and when required to the Chief Inspector. For example, the aforementioned incident which had occurred involving the intimate care of resident, at the time of this inspection, had not been reported or reviewed to determine if it required notification to the authority.

Judgment: Substantially compliant

Quality and safety

While residents who lived in this centre experienced a good quality of life and received good support from staff with regards to their social care needs, there were some aspects to the service delivered to them that required improvement.

The provider had a risk management system in place to support the identification, reporting, response and monitoring of risk in this centre. However, the inspector found that this system was not always effectively implemented, whereby, incidents that were occurring in the centre were not always reported. For example, the centre's intimate care policy guides on the requirement to complete an incident report where any changes to residents' skin care status is observed; however, this was not consistently occurring. Furthermore, prior to this inspection, the Chief Inspector was made aware of an incident which had occurred in relation to the intimate care of a resident. The inspector discussed this with the person in charge,

who acknowledged that this incident did occur; however, they informed the inspector that an incident report was not completed and were unable to provide any documentation in relation to the context of the incident. The failure of these incidents to be appropriately identified, recorded and ensure learning from, in line with the provider's own policies, directly impacted the provider's ability to adequately risk assess these incidents and put measures and actions in place, proportionate to the risk identified on residents' quality and safety of care.

The residents living in this centre required an assessed level of staff support with regards to their intimate care needs and an adequate number of staff were on duty each morning to allow for this. However, as previously mentioned, as there was a failure to adequately report an incident involving the intimate care of one resident, this had a direct impact on the overall effectiveness of the safeguarding arrangements in this centre. The failure to report this incident meant no review or investigation into the incident was conducted by the provider, in line with national policy for safeguarding, to establish if there was any concern to the safeguarding or rights and dignity of this resident. In addition to this, from discussions with the person in charge and staff, they identified that from time to time, some residents experienced changes to their skin integrity, some of which included the onset of bruising. However, at the time of this inspection, there was no guidance available to staff to guide them on what to do when residents presented with bruising, so as to rule out any safeguarding concern.

Arrangements were in place to ensure residents' needs were re-assessed on a minimum annual basis; however, improvements were required to ensure better adherence, where further review of these needs are required to reflect changes in residents' needs and circumstances. For example, where residents' presented with frequent changes to their skin integrity status, there was inconsistencies in the completion of their re-assessment and also in ensuring that personal plans, in respect to this aspect of their care, were updated. The failure to update these documents meant that staff supporting these residents did not have up-to-date guidance available to them, to guide them on how to support these residents, during times where changes to their skin integrity status occurred. Similar findings were found to one resident's intimate care plan, whereby, following an intimate care related incident, their intimate care plan was not updated to include any additional safeguarding and privacy and dignity arrangements.

Where residents required behavioural support, the provider had ensured adequate arrangements were in place for the regular multi-disciplinary review of their behavioural support interventions. Staff who spoke with the inspector were familiar with residents' specific behavioural support needs and of the recommended reactive and proactive strategies to be implemented on a daily basis to support them. However, there was some improvement required to ensure adequate guidance was available to staff, so as to support them in responding effectively to particular behavioural related incidents. For instance, for one resident who required behavioural support, following an incident which had recently occurred while this resident was on transport, there was no protocol in place or consideration given within their behaviour support plan, to guide staff on what to do, should a similar

incident of this nature occur again while this resident was on transport.

Although this inspection did identify an number of significant improvements to the quality and safety of service delivered to these residents, this didn't take from the consistent care and support that they received from staff, who ensured residents had optimum opportunities for social engagement, in accordance with their personal preferences and capacities.

Regulation 26: Risk management procedures

Although the provider had a risk management system in place, this system required review to ensure its overall effectiveness in identifying risks, assessing these risks and ensuring measures and actions are put in place in response to the risks identified. The deficits found upon this inspection with respect to the reporting of incidents, significantly compromised the provider's ability to investigate, if required, and learn from incidents, as and when they occurred.

Improvement was also required to aspects of risk assessment to ensure timely re-assessment of residents' care and support needs, where incidents impacting their care and support occurred. For example, where residents' presented with frequent changes to their skin integrity status, improvement was required to ensure an appropriate risk assessment was in place to demonstrate what control measures were put in place to monitor for this.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

A key-worker system was in operation within this centre to ensure resident's individual assessments and personal plans were reviewed on a minimum annual basis. However, improvement was required to ensure that where incidents or changes to residents' care needs occurred, that residents' assessments and personal plans were updated, as and when required, to adequately guide staff on any changes to their care and support arrangements, particularly in relation to skin integrity and intimate care personal plans.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Where residents required behavioural support, the provider had ensured these residents' behavioural support interventions were subject to regular multi-disciplinary review. However, for one resident, in response to a recent behavioural related incident which had occurred while the resident was on transport, there was no clear guidance available to guide staff on how to respond, should a similar incident of this nature occur again on transport.

Judgment: Substantially compliant

Regulation 8: Protection

There were some safeguarding plans in place in this centre and of the staff who spoke with the inspector, they were aware of these plans and of how to effectively implement them.

However, improvement was required to the overall safeguarding arrangements in place to ensure that where incidents of a safeguarding nature occur, these are reported and that the person in charge puts an investigation in place relation to any incident or allegation of a safeguarding nature and takes appropriate action, in accordance with national policy. The failure of an intimate care related incident that occurred in this centre, to be reported meant there was no further review of this incident completed by the provider to establish if there was any safeguarding concern to the resident involved. This also impacted the provider's ability to demonstrate and ensure that adequate safeguarding measures were implemented, to ensure that staff providing intimate care to all residents, did so in line with residents' personal plans, in a manner that respects residents' dignity and bodily integrity.

Improvements were also required to ensure adequate guidance was available to demonstrate how staff were to respond upon observing any explained and unexplained bruising to a resident to identify if there was any concern to residents' safety and welfare.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Portlaoise Area 2 OSV-0002488

Inspection ID: MON-0037913

Date of inspection: 14/09/2022

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 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The governance and management systems will be reviewed to ensure the oversight of the safety and quality of care is effective in all areas in particular the process of risk management and incident reporting in particular clinical care risks and safeguarding concerns.

The HSE Risk Manager is meeting all staff to complete training on HSE Policy in Incident Management and Reporting. This training will incorporate incident reporting, risk assessment and risk register development.

The oversight and monitoring systems are being reviewed. A new protocol has been developed and implemented in the centre on incident reporting and escalation which has been discussed with all staff.

The policies and procedures for risk management and safeguarding are now a standing agenda item on the staff team meeting. Incident reviews and audit outcomes will be discussed with staff to ensure shared learning and mitigate the risk of similar repeat events.

A monthly review of all risks in the centre is in place to identify any patterns or trends. Audits will be completed of care plans and incidents to identify areas for improvement and ensure reporting of all matters in line with the policy of the centre.

Resident individualised risk assessments, personal plans, safeguarding and behavior support plans where applicable are presently being reviewed to ensure they address the needs of each resident.

Refresher training in Safeguarding is being completed by all staff.

The clinical nurse specialist in Behavior Support is completing training with staff in responsive behavior management.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
A new protocol for reporting of incidents is in place. All staff are being trained in incident reporting and risk management in line with policy of the centre.

The incident in relation to a resident has been reviewed. In this case, the incident which occurred involving the intimate care of a resident has been examined. It has been determined the intimate care plan did not fully meet the personal needs of the resident. The intimate care plan has been updated to address the needs of the resident in detail.

The two incidents have been retrospectively notified to HIQA in the aftermath of the inspection.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
All staff are completing training on the HSE Policy in Incident Management and Reporting. This training will incorporate incident reporting, risk assessment and risk register development.

A new protocol for reporting of incidents is in place. This has been introduced and discussed with the staff team.

A monthly review of all risk in the centre is in place to identify any patterns or trends in incident reporting to ensure improvement plans can be developed.

All staff are aware of the necessity to report incidents in line with the new protocol which includes guidance to notify the PIC or the on call manager during out of hours when an incident occurs and to complete the required incident forms.

All staff are completing training on risk assessment and incident reporting. Individual

risk assessments in each resident's care plans are being reviewed to ensure they address all their current care needs and guide staff in their actions and care interventions.

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:
The personal plans of residents are being reviewed and updated.

The intimate care plans for each resident have been reviewed to ensure they meet the current personal care needs of each resident.

The Behavior Support Plans are being reviewed by the behavioral support therapist to ensure the Pro Active and Reactive Strategies are sufficiently and accurately detailed to guide staff interventions.

Residents individualised risk assessments are being reviewed to ensure actions are in place to mitigate any hazard while simultaneously promoting residents' independence and dignity.

The new protocol requires the reporting of all incidents in line with the center's policy. In addition particularly, skin integrity concerns and unexplained bruising. The completion of a body map chart and daily nursing evaluations to be documented in the resident's care plan is emphasised in the protocol.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The Behavior Support Plans are being reviewed by the behavioral support therapist to ensure the Pro Active and Reactive Strategies are sufficiently and accurately detailed to guide staff interventions.

Resident individualised risk assessments are being reviewed to ensure actions are in place to mitigate any hazard while simultaneously promoting residents' independence and dignity.

Evidenced based behavior monitoring charts are being completed to monitor and inform risk assessments and behaviors support plan reviews and development.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
A new protocol has been developed and implemented in the centre on incident reporting and escalation which has been discussed with all staff. All safeguarding concerns will be investigated in line with the policy of the centre.

All staff are completing refresher training on Safeguarding.

A monthly review of all risks in the centre is in place to identify any patterns or trends. Audits will be completed of care plans and incidents to identify areas for improvement and reporting of all matters in line with the policy of the centre.

Safeguarding is a standing agenda item on the staff team meeting and is discussed with each staff member during their supervision appraisal.

The two incidents in relation to safeguarding have been notified to HIQA retrospectively. Both incidents are being investigated currently in line the HSE policy on Safeguarding Vulnerable Adults. Preliminary screening forms have been completed and referred to the Designated Officer for Safeguarding and the Social Worker in line with the policy of the service. Interim safeguarding plans are in place and will be reviewed on the guidance of the Adult safeguarding social worker.

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 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 safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	01/11/2022
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.	Not Compliant	Orange	01/11/2022
Regulation 26(2)	The registered	Substantially	Yellow	31/10/2022

	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.	Compliant		
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Substantially Compliant	Yellow	13/10/2022
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.	Substantially Compliant	Yellow	13/10/2022
Regulation 07(1)	The person in charge shall	Substantially Compliant	Yellow	04/11/2022

	ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.			
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	08/10/2022
Regulation 08(6)	The person in charge shall have safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.	Not Compliant	Orange	07/10/2022