Liffey 4 (Sheaf Valley), OSV-0005781, 19 March 2019

Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	Liffey 4 (Sheaf Valley)
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Dublin 24
Type of inspection:	Unannounced
Date of inspection:	19 March 2019
Centre ID:	OSV-0005781
Fieldwork ID:	MON-0026431

About the designated centre

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

The designated centre is comprised of two apartments and two community houses based in the West and South West of Dublin and provides residential services for up to 12 persons. Residents are supported by a staff team of social care workers and a social care leader who also holds the role of the person in charge of the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
19 March 2019	09:00hrs to 18:00hrs	Thomas Hogan	Lead
19 March 2019	09:00hrs to 18:00hrs	Erin Clarke	Support

Views of people who use the service

The inspectors met with five residents who were availing of the services of the centre and spoke in detail with two residents. Overall, residents communicated high levels of satisfaction with the service they were in receipt of and told the inspectors that they felt safe. Residents spoken with were knowledgeable on the complaints process which was available and had been informed of their personal rights.

Capacity and capability

The inspectors found that there were mixed levels of compliance with the regulations inspected against. Care and support being delivered to residents was observed to be timely and respectful and the inspectors found that there was clear evidence of a person-centred culture in the centre. There were; however, a number of areas of non-compliance identified through the inspection process. The inspectors found that while residents were cared for and supported for in a warm and positive manner by the staff team, there was a need for strengthening of the oversight of the centre.

Staffing arrangements for the centre were reviewed by the inspectors and it was found that there were appropriate skill mix and number of staff members employed to meet the identified needs of residents. Staff members were observed to provide timely care and support to residents and all interactions were noted to be kind and respectful between staff members and residents.

The inspectors reviewed staff training records and found that there were deficits in five of six mandatory training programmes. There was limited oversight of staff training and records were not available for all staff members employed in the centre. Arrangements in place in the centre for the formal supervision of staff members was found not to be satisfactory. Records of completed supervisions was not available for the majority of the staff team and where records were available, the content was task orientated and poorly recorded. The inspectors found that there were no policies or guidelines in place relating to staff training and development or staff supervision and as a result there was an absence of appropriate direction and oversight in these areas.

The governance, management and oversight of the centre was reviewed by the inspectors and it was found that while annual reviews and six monthly unannounced visits were being completed by the registered provider, these mechanisms failed to self-identify areas of non-compliance or risk. For example, internal auditing tools had not identified deficits in staff training or supervision

arrangements and had not identified the failure in the risk management systems to identify and assess all presenting risks. The inspectors met and spoke with the person in charge and a newly appointed person participating in management and both demonstrated appropriate knowledge of the relevant legislation, regulations and national policy.

The inspectors reviewed a sample of resident files and found that all had a written contract of care in place. There were some inconsistencies noted in the contracts with differing charges being outlined in different sections of the contracts. A review of the admission procedures found that recent transfers within the centre were appropriately managed and respected the individual wishes and met the needs of residents.

A review of incident, accident and near miss records was completed by the inspectors and it was found that all required notification of incidents to the Office of the Chief Inspector had been completed as required by the regulations.

The inspectors reviewed policies and procedures in place in the centre and maintained on the organisation's intranet service. A number of policy documents were found not to have been reviewed within the required three yearly time frames and two policies were not available in the centre.

Regulation 15: Staffing

The inspectors found that there were sufficient number of staff employed in the centre with the necessary competencies to meet the needs of residents.

Judgment: Compliant

Regulation 16: Training and staff development

The inspectors reviewed staff training records and found that a number of staff members had not completed training or refresher training in a number of mandatory areas as outlined as required by the person in charge. These were as follows:

- three staff members had not completed training or refresher training in manual handling
- one staff member had not completed training or refresher training in safeguarding vulnerable persons
- one staff member had not completed training in children first
- at least five staff members had not completed training or refresher training in the safe administration of medication
- at least five staff members had not completed training or refresher training in

break away techniques

Training records were not available for all members of the staff team employed in the centre.

Arrangements in place for the formal supervision of staff members was not satisfactory. Records of supervision meetings were not available for a majority of the staff team and records which were available demonstrated that supervision was task orientated and poorly recorded.

Judgment: Not compliant

Regulation 23: Governance and management

There was limited oversight of some areas of care and support being delivered to residents. Internal auditing mechanisms failed to self-identify areas of non-compliance and risk such as staff training, supervision, risk management, issues relating to the premises of the centre, fire safety and policies and procedures.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

A sample of written contracts of care were reviewed by the inspectors and it was found that there were some inconsistencies regarding the charges to residents in separate sections of the agreements which resulted in a lack of overall clarity.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The inspectors found that notifications had been made to the Office of the Chief Inspector as required by the regulations.

Judgment: Compliant

Regulation 4: Written policies and procedures

A number of policies were found not to have been reviewed within a three year time period as required by the regulations. These were:

- the policy relating to the provision of personal intimate care
- the policy relating to the prevention, detection and response to abuse, including reporting of concerns and/or allegations of abuse to statutory agencies and
- the policy relating to the monitoring and documentation of nutritional intake.

In addition, the inspector found that two policies identified as being required by the regulations were not in place or available at the time of inspection. These were:

- the policy relating to the recruitment, selection and vetting of staff and
- the policy relating to visitors.

Judgment: Not compliant

Quality and safety

While the inspectors found some strong evidence that residents experienced a good quality of life while availing of the service of this centre, there was also evidence which demonstrated a requirement for improvement and further development to ensure regulatory compliance and the delivery of services of a high standard.

The inspectors found that improvements were required in the oversight and the management of residents' finances. Practices relating to the management of resident finances by the registered provider required review and development to ensure that appropriate systems were in place and that supports which were being provided were safe and transparent.

A review of the general welfare and development of residents found that there were appropriate supports in place to ensure residents experienced a good quality of life. The inspectors found that there was evidence of supports for residents to effectively exercise their right to independence, social integration and participation in the life of the community. Some residents were found to be attending day services while others were engaged in part-time paid employment. Residents also engaged in a wide variety of activities and social roles including partaking in an animal volunteer role and attending social clubs in the local community.

The inspectors completed a full walk through of the premises of all four units of the centre in the company of staff members. While the premises of one unit was found to be of a satisfactory standard, the premises of the remaining three units were not kept in a good state of repair. In one of the units of the centre the inspectors found that there were considerable repairs required and damage was noted to walls, doors, and flooring in a number of areas. In addition, the inspectors found that this unit was not cleaned to a satisfactory standard. Painting and decoration was

required throughout the premises. The inspectors observed that a shower head in a bathroom area was held up through the use of sticky tape. In the premises of two apartments the inspectors found that painting and decoration was also required in a number of areas. In these areas the inspectors observed curtains and curtain poles falling off walls, and a number of areas with considerable markings on the walls.

A review of the risk management policy in place in the centre (dated July 2018) found that a number of areas outlined as required by the regulations were not contained in the document. There was a satisfactory system in place for the recording and responding to incidents, accidents and near misses. A risk register was reviewed by the inspectors and it was found that all risks were not identified and assessed by the management team. For example, the risks associated with residents spending unsupervised periods alone in the centre were not assessed despite recent related hazards being identified through an incident in the centre.

The inspectors reviewed fire safety precautions in place in the centre and found that there were deficits in fire containment measures. There were no self-closing mechanism fitted to fire doors and in a number of units the inspectors observed fire doors to be wedged open. Records maintained in some areas of the centre relating to completed fire drills were poor and did not outline specific information such as the exact time taken to evacuate the premises. The practices relating to recording of fire drills differed between individual units of the centre and in one area the inspector found detailed records maintained. In another unit of the centre there was no emergency lighting in place for the main emergency exit route.
Personal emergency evacuation plans (PEEPs) were noted to be ambiguous and did not provide specific direction on supporting residents in the case of emergency in some instances.

Medication management practices were reviewed by the inspectors and it was found that medication was not stored securely as a result of local practices of storing medication keys in an unlocked manner. All medications contained in the medication cabinet were within stated expiry dates. A sample of medication prescriptions and administration records were reviewed and were found to contain the required information. Self-administration of medication capacity and risk assessments had not been completed for a number of residents availing of the services of the centre.

The inspectors spoke with a number of residents and staff members about safeguarding and protection. Residents communicated that they felt safe while availing of the services of the centre and staff members demonstrated clear and appropriate knowledge of the different types of abuse and what actions to take if abuse was ever witnessed or suspected. The inspectors were assured that there were appropriate systems in place for managing and responding to incidents of a safeguarding nature should they occur in the centre.

Regulation 12: Personal possessions

Practices relating to the management and oversight of resident finances in the

centre required review and strengthening. It was unclear to the inspectors why a number of lodgments of residents' funds were made to an organisational account.

Judgment: Substantially compliant

Regulation 13: General welfare and development

The inspectors found that residents were supported to develop and maintain personal relationships and links with the wider community and natural networks in accordance with their wishes.

Judgment: Compliant

Regulation 17: Premises

In three of four units of the centre the inspectors observed that the premises were not maintained and kept in a good state or repair. Painting and decoration was required in all three areas. In one unit, there was considerable improvements required which included intensive cleaning, replacement of wall and flooring coverings, window blind replacements, shower fittings and review of heating arrangements for the unit.

Judgment: Not compliant

Regulation 26: Risk management procedures

A risk management policy (dated July 2018) was found not to contain a number of areas outlined as being required by the regulations. These were:

- the measures and actions in place to control the accidental injury to residents, visitors or staff
- the measures and actions in place to control aggression and violence and
- the arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.

The inspectors found that all presenting risks had not been identified and assessed.

Judgment: Not compliant

Regulation 28: Fire precautions

There were no self-closing mechanism fitted to fire doors and in a number of units the inspectors observed fire doors to be wedged open. In some units of the centre there were poor record keeping practices relating to fire drills and as a result it was unclear what specific times were taken to fully evacuate the building. In one unit there was no emergency lighting in place for one emergency exit route. PEEP documents in some areas of the centre did not outline the specific support requirements of residents in the event of an emergency.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The inspectors found that medication stored in the centre was not securely stored due to local arrangements relating to medication keys. Two of eight residents had capacity and risk assessments completed for the self-administration of medication.

Judgment: Substantially compliant

Regulation 8: Protection

The inspectors found that residents were protected from experiencing abuse while availing of the services of the centre.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Liffey 4 (Sheaf Valley) OSV-0005781

Inspection ID: MON-0026431

Date of inspection: 19/03/2019

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Reg 16 (1)(a) - Local operational procedure developed and in place, outlining Mandatory training timeframes and the system in place to ensure all staff are appropriately trained as part of their continuous professional development. - All mandatory and refresher training has been scheduled for the team for the remainder of the year. - A clear and transparent training log has been developed and implemented and standardised across all DCs in the region. Reg 16 (1)(b) - Supervision schedule has been developed for all staff. - Additional supervision guidance and information has been furnished to the DC PIC to support them in providing more effective and supportive supervision meetings.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Reg 23 (1)(c) - An overarching oversight document for the Designated Centre has been developed to ensure the internal auditing process is effective. This auditing tool will address oversight	

of the person in charge's governance responsibilities including, Staff Training, Staff Supervision, Risk Management, Fire Safety, Environment & Organisational Policies and Procedures.

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services: Reg 24 (4) (a) - The Person in charge has reviewed all contracts of care in line with the regulations and ensures that they information on each Contract of Care is consistent and transparent.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: Reg 4 (1) - All Schedule 5 policies and procedures are now available in the appropriate folder in the designated centre. - A plan is in place to update all policies in line with organisational review dates. - Reference to the Safeguarding policy, the organisation have adopted the HSE policy and this effectively guides staff practice in relation to protecting residents from the risk of potential abuse. We also have a safeguarding statement specific to SJOG that sits with the policy. And in addition to this, we have a local safeguarding procedure in place.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions: Reg 12 (1) - The Person in Charge will ensure there is on-going transparency in managing where necessary, service users financial affairs.

- A local operational procedure will be developed to guide and inform staff of the system in place in the designated centre to effectively manage service user's finances.

Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Reg 17 (1) (b) & 17 (7) - A list of maintenance requirements has been resent to the maintenance department to be completed as a matter of priority. 17 (1) (c) - Cleaning schedules for the DC has been updated and PIC will complete scheduled spot checks and audits of the areas.	

Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Reg 26 (1) (b) - There has been a new Risk Management Policy launched in 2019. Person in Charge attended training on risk management for this policy on 08 04 19. - The risk management system for this designated centre will be reviewed and updated in line with this new policy. - All required risk assessments will be completed and filed. Risk Register for the designated centre will be reviewed and updated to reflect this. - The local risk management policy will be updated to include all relevant risks in the designated centre - All risk assessment and risk register are reviewed in line with the relevant timeframes.	

Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Reg 28 (2) (a)	

- The person in charge will arrange for all works in relation to fire in the designated are completed within the highlighted timeframe. (Self-closures to be fitted to all internal doors in the Designated Centre, Emergency lighting to be installed in exit route of one area)
- All PEEPs in the designated centre are to be updated with a more robust and detailed information outlining the individualised support requirements for each resident in the event of them needing to evacuate the building in an emergency.
- A new fire drill record template has been introduced in the designated centre to ensure all relevant information is captured and documented for fire drills including individual evacuation times.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Reg 29 (4) (a)
- A review of the local arrangement regarding medication keys in one area has been completed and this system has been improved and is secure.
- Remaining six residents have had risk assessments completed for the self-administration of medication.

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	16/04/2019
Regulation 12(4)(a)	The registered provider shall ensure that he or she, or any staff member, shall not pay money belonging to any resident into an account held in a financial institution unless the consent of the person has been obtained.	Substantially Compliant	Yellow	16/04/2019
Regulation 12(4)(b)	The registered provider shall ensure that he or	Substantially Compliant	Yellow	16/04/2019

	she, or any staff member, shall not pay money belonging to any resident into an account held in a financial institution unless the account is in the name of the resident to which the money belongs.			
Regulation 12(4)(c)	The registered provider shall ensure that he or she, or any staff member, shall not pay money belonging to any resident into an account held in a financial institution unless the account is not used by the registered provider in connection with the carrying on or management of the designated centre.	Substantially Compliant	Yellow	16/04/2019
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	30/06/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/06/2019
Regulation 17(1)(b)	The registered provider shall	Not Compliant	Orange	30/09/2019

	ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	30/06/2019
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	30/06/2019
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	30/06/2019
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be	Substantially Compliant	Yellow	30/06/2019

	charged.			
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: accidental injury to residents, visitors or staff.	Not Compliant	Orange	31/07/2019
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: aggression and violence.	Not Compliant	Orange	31/07/2019
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures	Not Compliant	Orange	31/07/2019

	might have on the resident's quality of life have been considered.			
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.	Not Compliant	Orange	31/07/2019
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	30/09/2019
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	30/09/2019
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/09/2019
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,	Not Compliant	Orange	30/07/2019

	residents, are aware of the procedure to be followed in the case of fire.			
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	16/04/2019
Regulation 29(5)	The person in charge shall ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability.	Substantially Compliant	Yellow	16/04/2019
Regulation 04(2)	The registered provider shall make the written policies and procedures referred to in paragraph (1)	Not Compliant	Orange	31/05/2019

	available to staff.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	30/09/2019