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Helensburgh, OSV-0001703, 11 June 2018

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

Name of designated centre:	Helensburgh
Name of provider:	Sunbeam House Services Company Limited by Guarantee
Address of centre:	Wicklow
Type of inspection:	Announced
Date of inspection:	11 June 2018
Centre ID:	OSV-0001703
Fieldwork ID:	MON-0021434

About the designated centre

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

Helensburgh designated centre is located in a small town in Co. Wicklow and can provide residential care for up to six male or female residents over the age of 18 years as per the provider's statement of purpose. The centre provides services and supports for adult residents with intellectual disabilities. The centre is managed by a full-time person in charge who also has responsibility for a day service. A senior services manager is also assigned to the centre and provides supervisory support to the person in charge. The centre is staffed by a whole-time-equivalent number of 6.41 social care workers, as per the provider's statement of purpose. Residents are supported to engage in community based day programmes and training programmes.

The following information outlines some additional data on this centre.

Current registration end date:	25/08/2018
Number of residents on the date of inspection:	6

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
11 June 2018	10:10hrs to 18:20hrs	Ann-Marie O'Neill	Lead

Views of people who use the service

Residents spoken with during the inspection said yes when asked if they liked living in the centre. Residents also spoke about recent birthday celebrations they had and others mentioned they liked shopping. Some residents spoken with did not provide specific feedback about the centre but engaged in brief conversations about what their plans were for the day, birthday celebrations they had recently and musical interests they had. Residents observed during the inspection appeared content and happy in their home and enjoyed going for walks with staff to get the paper in the local town. Residents were also observed engaging in pastimes in the centre during the day and watching movies they enjoyed. Feedback questionnaires completed on behalf of residents indicated residents were happy living in the centre and felt the service provided met their needs. Residents living in the centre had experienced a bereavement in recent times and mentioned this to the inspector during the inspection.

Capacity and capability

The provider had systems in place to ensure the centre was regularly monitored and reviewed from a provider level, improvements were required to ensure operational management auditing and review were carried out in an effective and consistent manner. Improvements were also required to ensure staff received refresher training in both mandatory and additional training areas to effectively support residents assessed needs and to maintain their skills at an optimum level.

A clearly defined management structure was in place which ensured lines of accountability and authority within the centre. The person in charge had responsibility for this designated centre and a day service. The person in charge based themselves mostly in the designated centre. They were supported in their role by a senior services manager.

A provider led audit programme was in place to ensure areas of practice were regularly monitored and reviewed. Comprehensive six monthly provider-led audits and an annual review of the service had occurred in line with the requirements of the regulations.

However, six monthly provider-led audits consistently demonstrated a high level of actions were required each time to bring about improved compliance and standards in the centre. While it was evident that provider-led audit systems were identifying key areas for improvement; operational management auditing systems were not adequate to ensure consistent review of the quality of care and compliance with

regulations in this centre. Quality review systems in the centre at the time of inspection relied on provider-led auditing and Health Information and Quality Authority (HIQA) inspection reports for the most part.

Effective staffing arrangements ensured that the number and skill-mix of staff working in the centre met the assessed needs of residents, ensuring residents received continuity of care and the support they required. Despite a recent reduction in resident numbers, the provider maintained the staffing resources as they had been in order to better meet the assessed needs and supports required for residents.

Staff received supervision from the person in charge however, supervision meetings did not occur at frequent enough intervals to ensure staff received consistent supervisory support from their manager to address any arising practice issues and to offer staff guidance and support where required. A planned and actual roster was in place which identified staff on duty both day and night. Staff meetings were occurring, which kept staff up-to-date on changes happening within the organisation. Although a system was in place to ensure staff received regular training, a number of gaps in refresher training, across a range of areas, was identified in training records for staff.

Although there were no complaints being managed at the time of this inspection, the provider had a complaints policy in place which guided staff on how to respond to, manage and record complaints. A nominated person was identified to deal with complaints and residents had access to an appeals procedure and advocacy services as required. The complaints procedure was displayed in the centre. An action from the previous inspection in relation to the complaints procedure had been addressed.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted an application to renew registration for this centre in a timely way however, not all information required had been received. Medical declaration information was not submitted as required for some persons participating in the management of the centre.

Judgment: Substantially compliant

Regulation 14: Persons in charge

The registered provider had appointed a person in charge to the designated centre. This person had the regulatory required qualifications and experience relevant to their appointment.

Judgment: Compliant

Regulation 15: Staffing

With the reduction in capacity staffing resource arrangements could now better meet the assessed needs and number of residents living in the centre. A planned and actual roster was maintained.

Schedule 2 files were not reviewed as part of this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Staff training required improvement in this centre. There were a number of gaps found in both mandatory training and refresher training to meet the assessed needs of residents.

Supervision meetings between the person in charge and staff had occurred but not at frequent enough intervals to ensure consistent supervisory oversight of staff.

Judgment: Not compliant

Regulation 19: Directory of residents

The directory of residents was updated during the course of the inspection.

Judgment: Compliant

Regulation 23: Governance and management

The provider had met their regulatory requirements by ensuring an annual report for the centre had been completed for the previous year. Comprehensive six monthly provider led audits had also been completed with action plans devised following each audit. Six monthly provider led audits indicated numerous improvement actions were required after each visit. An operational management auditing system was not in place which could provide consistent day-to-day review of the quality of

care provided.

Judgment: Not compliant

Regulation 3: Statement of purpose

A statement of purpose that included the requirements of Schedule 1 of the regulations was in place.

Judgment: Compliant

Regulation 31: Notification of incidents

Some forms of chemical restraint had not been notified to the Chief Inspector on a quarterly basis as required by the regulations.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector found the provider had arrangements in place which ensured residents were supported to live their lives as they wished and that they received safe care. Some improvements were required to enhance the quality of care provided and to ensure supports provided were in line with residents' assessed needs.

The provider had ensured the location of Helensburgh designated centre could meet residents' community participation needs and promote residents' full integration with their local community. The designated centre was located in a small vibrant town in County Wicklow with local amenities a short walk away for residents. The premises was well maintained throughout and actions from the previous inspection in relation to bathing facilities had been addressed to a good standard.

Safeguarding arrangements ensured that the provider was implementing procedures in line with the National Safeguarding Vulnerable Adults. Staff who spoke with the inspector were aware of the safeguarding policy and procedures and also of their responsibility to report safeguarding concerns to the person in charge and/or designated officer assigned to the centre. Some residents presented with safeguarding risks which required specific safeguarding strategy management and interventions. Improvement was required to ensure safeguarding planning was in

place to guide and inform staff in how to manage those safeguarding risks and how to respond in a consistent, robust way should they occur.

Where residents presented with behaviour that challenges, behaviour support planning was in place. At the time of inspection some such plans were under review by a relevant allied health professional. In some instances behaviour support planning referred to compatibility issues that had presented in the centre in the past, these plans had not been updated to reflect current circumstances. This required improvement.

Some restrictive practices were in place at the time of inspection, however; these had not been identified as such. The person in charge made additions to the restraint register for the center during the course of the inspection. It was demonstrated that some forms of chemical restraint were under review by an allied health professional in line with organisational policies and procedures related to the use of restrictive practices.

Residents were facilitated to access training and education if they wished and some attended local community groups and attended community based day services. In response to the aging needs of some residents the provider had reduced the number of days those residents attended day services and had put additional staff supports in the centre for residents on their day off. Residents were also supported to develop and maintain personal relationships with friends and family and told the inspector about a recent important birthday celebration they had in their home where their friends and families attended. They told the inspector that it was a very happy and special occasion for them.

Personal planning arrangements ensured that plans were in place to guide staff on the support required by residents. Improvements were required however, a comprehensive annual assessment of need had not been completed for residents. This was required to ensure resources and support planning was adequately meeting the assessed needs of residents.

Risk management arrangements ensured overall that residents were safe from identified risks. Where incidents occurred in the centre, these were logged on an electronic incident recording system and risk rated. Incidents were reviewed by the person in charge and for more serious incidents, reviewed also by the senior services manager. A risk register was in place which captured most risks and hazards in the centre, improvement was required however to ensure all risks in the centre were captured and appropriately risk rated on the register, for example infection control, safeguarding risks, risks to staff associated with handling of some forms of medication.

The provider had not ensured appropriate infection control policies and procedures were in place to support and guide staff in best practice guidelines. The inspector did observe staff engage in some aspects of appropriate infection control practice but this was carried out in the absence of standard operating procedures and policy guidelines in place.

The provider had put adequate fire safety precautions and containment measures in

place, including, regular fire drills, regular fire checks of fire fighting equipment and fire doors throughout. Fire exits were maintained unobstructed and a fire exit was available to residents, visitors and staff from the first floor of the centre. Accessible exit routes from the side and rear of the premises were also available for wheelchair users and residents with reduced mobility.

It was not demonstrated however, that the provider had assessed if residents required evacuation aids to support and promote timely and effective evacuation from the centre. Personal evacuation plans did not provide guidance for staff of the evacuation aids or additional measures to be implemented should a resident not wish to engage in evacuation of the centre. Fire drill documentation indicated some residents had been reluctant or refused to engage in an evacuation drill on some occasions.

The provider had ensured safe medication management systems were in place. The inspector observed that medications were securely stored in the centre. Residents had access to their own pharmacist and medications were supplied to the centre in a pre-dosed package system on a weekly basis. Medications received were logged when received and checked against medication administration charts. Some medications prescribed to residents required specific measures in place to prevent health-care risks to staff if handled without taking appropriate measures. It was demonstrated that these medications were appropriately managed and the pre-packed dosage system mitigated medication handling risks. However, this risk had not been captured in the centre's risk register.

Regulation 17: Premises

Actions from the previous inspection in relation to bathing facilities on the first floor of the centre had been addressed. Overall, the premises presented as a spacious and homely environment located in a prime location to meet residents social care needs.

Judgment: Compliant

Regulation 26: Risk management procedures

An organisational risk management policy was in place which met the regulations. Evidence of the implementation of the policy for the most part was found on this inspection. Improvement was required to ensure all risks managed in the centre were incorporated as part of the risk register for the centre.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The organisation's infection control policy was not in date and did not provide adequate guidance for staff to manage infection control risks and incidents in designated centres. For example, the policy did not guide staff in how to implement best practice infection control for the laundering of soiled clothes and linen. The inspector did observe staff implement infection control measures at a local level but this was in the absence of organisational guidance or standard operating procedures outlining infection control best practice.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were adequate fire safety systems in this centre. Some improvement was required to ensure residents had been assessed with regards to evacuation aids and strategies which may be required in the event where a resident refused or could not independently evacuate from the centre. Fire drill documentation indicated on occasion some residents had refused or were reluctant to participate in evacuation drills.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Medication management systems reviewed by the inspector met with compliance.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Residents had not received a comprehensive annual assessment of needs as required by the regulations.

Judgment: Not compliant

Regulation 6: Health care

Residents health-care needs were managed to an adequate standard. All residents had received an annual health check by their General Practitioner (GP). Residents were also supported to attend hospital appointments as required and in some instances this was required up to three times a week for a specific health-care need.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where required residents had behaviour support planning in place. Allied health professional reviews of some plans were underway at the time of inspection. A chemical restraint medication was added to the restrictive practice register for the centre during the course of the inspection.

Some behaviour support planning referred to compatibility issues that were a feature in the centre prior. These plans required review and updating to reflect a change in circumstances.

Judgment: Substantially compliant

Regulation 8: Protection

There was evidence that the provider was implementing the National Safeguarding Vulnerable Adults policies and procedures within this designated centre. Improvement was required. some personal safeguarding risks for residents did not have an associated safeguarding plan in place to guide staff in their management and to direct robust staff response guidelines if and when they occurred

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Substantially compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Helensburgh OSV-0001703

Inspection ID: MON-0021434

Date of inspection: 11/06/2018

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Registration Regulation 5: Application for registration or renewal of registration	Substantially Compliant
<p>Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration:</p> <p>Updated information has been provided to HIQA. </p>	
Regulation 16: Training and staff development	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>Staff who needed refresher courses or training have been booked onto the appropriate courses. Most will be completed in August and September and all staff in question will have been trained by the 15/11/2018. Should spaces become available in earlier courses the training will be completed earlier.</p> <p> </p>	
Regulation 23: Governance and management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>CSM to plan regular supervision for all staff in line with policy by 20/07/2018.</p> <p>Regular (monthly) audits to be carried out to ensure progress on action plans from this and the internal six monthly inspections.</p>	

Audits and checks of the service provided will be carried out monthly (or more regularly if required) as part of an increase in focus on the operational management of the location. Audits will include structured regular reviews of personal plans, petty cash audits, client cash audits, reviews of risk register, more robust methods of medication press/administration audits, infection control audits (once policy is in place), reviews of the needs assessments to ascertain if they need to be repeated, reviews of PBSP's, evacuation reports etc. These will be formally developed and planned by 30/07/2018 and completed by 31/08/2018.

Infection control policy is in the process of being developed and will be reviewed by 31/08/2018 |

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

Continued restraint will be recorded on NF39 returns while the situation persists.

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

Current practice which controls risk to staff due to contact with medication to be included in risk register.

Risk of spreading infection and infection control measures to be included in Risk Register supported by the new infection control policy.

SHS social work team and HSE Safeguarding and Protection team to be involved in safeguarding plan for individual involving false allegations to ensure robust and appropriate recording of such events. This is to ensure that any disclosure is dealt with properly in line with National Safeguarding of Vulnerable Adults policy. This plan will be developed by 31/07/2018.

Senior management to discuss methods to capture obvious false allegations, supplemental, to current workflows, to ensure effective reporting

Current practices and environmental supports already in place to mitigate against falls to be recorded on risk register.

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Regulation 27: Protection against infection	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 27: Protection against infection:</p> <p>Company to introduce Infection Control Policy (currently in draft), when this policy is introduced it will be adhered to. While awaiting guidance from this policy, increased infection control measures have been introduced and the use of appropriate additional equipment has already started.</p> <p>]</p>	
Regulation 28: Fire precautions	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions:</p> <p>Clients who have shown reluctance in responding to the fire alarm have been through individual walk through discussions and rehearsals. PEEPS have been modified for relevant clients. These clients have all demonstrated a thorough understanding of the need to evacuate the premises and their reluctance was always overcome by some brief verbal encouragement. No client has ever refused to evacuate during a drill. Encouragement and reminders of the importance of fire drills will be emphasized during fire drills.</p> <p>Client with reduced mobility's ability to evacuate has been risk assessed and, while they take their time, they moved at a reasonable pace, thus the assessment indicated no need for further assistive equipment at this time – it is planned that this client will move to a downstairs room in the very near future thus further reducing the distance they would need to travel and removing entirely the fire escape as a risk for them during an evacuation.</p> <p>Sunbeam House Services' Health & Safety Officer will observe and evaluate a planned evacuation by 31/07/2018. Any shortcomings noted by the Health & Safety Officer will be acted upon to ensure that risks to the clients and staff are controlled as much as is practicable. This includes possible use of evacuation aids and a review as to whether there is a need for some environmental enhancement to increase the exit options for an individual.</p> <p>]</p>	
Regulation 5: Individual assessment and personal plan	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:</p> <p>All clients will have an annual assessment of needs and more regularly if needed. Clients with higher perceived change in needs will be prioritized and all will have this completed by 24/08/18.</p>	

This information will be passed to the referrals committee for funding and planning purposes as well as being used as an aid to focus supports within the location.

Personal plans to be reviewed regularly as part of increased focus on operational management and changed as necessary.

Regulation 7: Positive behavioural support

Substantially Compliant

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

Positive behaviour support plans will be updated and will reflect the current situation within the location by 31/07/2018. These plans will be reviewed and developed. It is envisaged that there will be a psychologist/behavior support specialist in the organization in the future. Input from a suitably qualified and experienced person will be welcomed.

Regulation 8: Protection

Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

SHS social work team and HSE Safeguarding and Protection team to be involved in safeguarding plan for individual involving false allegations to ensure robust and appropriate recording of such events. This is to ensure that any disclosure is dealt with properly in line with National Safeguarding of Vulnerable Adults policy. This plan will be developed by 31/07/2018.

Senior management to discuss methods to capture obvious false allegations, supplemental, to current workflows, to ensure effective reporting.

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
Registration Regulation 5(3)(b)	In addition to the requirements set out in section 48(2) of the Act, an application for the registration or the renewal of registration of a designated centre shall be accompanied by full and satisfactory information in regard to the matters set out in Schedule 3 in respect of the person in charge or to be in charge of the designated centre and any other person who participates or will participate in the management of the designated centre.	Substantially Compliant	Yellow	Complete 26/06/2018
Regulation 16(1)(a)	The person in charge shall ensure that staff	Not Compliant	Orange	15/11/2018

	have access to appropriate training, including refresher training, as part of a continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/07/2018
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	31/08/2018
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	31/08/2018
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated	Substantially Compliant	Yellow	31/08/2018

	infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	31/08/2018
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Substantially Compliant	Yellow	11/06/2018
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive	Not Compliant	Orange	31/08/2018

	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.			
Regulation 07(1)	The person in charge shall 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.	Substantially Compliant	Yellow	15/11/2018
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/07/2018