Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

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| Name of designated centre: | Clew Bay |
| Name of provider: | St Michael's House |
| Address of centre: | Dublin 11 |
| Type of inspection: | Unannounced |
| Date of inspection: | 16 August 2018 |
| Centre ID: | OSV-0002334 |
| Fieldwork ID: | MON-0024542 |

## About the designated centre

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

Clew Bay is a community home for adult residents with an intellectual disability. Residents are supported when required with budgeting, cooking and other activities of daily living. The centre consists of two premises within walking distance of each other. One premises is a two-storey, end of terrace house with five bedrooms, three bathrooms, a kitchen, dining and living spaces. The other premises is a terraced house situated on a cul de sac. Upstairs it has three bedrooms, one of which is ensuite and a bathroom. It has two sitting rooms, a kitchen/dining area and a utility room downstairs. Both premises are connected by adjoining back gardens and situated close to a local village in Co. Dublin. Facilities close by include shops, pubs, churches, garda station, credit union, banks, parks, a swimming pool and a library. The local shopping centre is a 10 minute walk and the area is well served by public transport. Care and support in the centre is provided by a person in charge and social care workers. Residents can access nursing support via the nurse manager on call service if required.

**The following information outlines some additional data on this centre.**

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| Current registration end date: | 30/09/2018 |
| Number of residents on the date of inspection: | 8 |

## 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 |
|---|---|---|---|
| 16 August 2018 | 08:30hrs to 18:00hrs | Marie Byrne | Lead |
| 16 August 2018 | 08:30hrs to 18:00hrs | Michelle McDonnell | Support |

## Views of people who use the service

The inspectors met and spoke with six of the eight residents who lived at the centre on the day of the inspection. Each of the residents who spoke with the inspector described meaningful activities which they participated in their local community. A number of residents told the inspectors about where they worked or attended day services. One resident was soon due to retire and described plans in place to stay busy and active following their retirement.

Residents told the inspectors about local transport links and how they could easily access local shops, banks, cinema and parks. All the residents who spoke with the inspectors outlined their involvement in the running of their home including decisions relating to meal planning and chores they were completing in their home. One resident described their role as the fire safety officer in the centre.

Residents were complimentary towards food choices in the centre, staff support, and their involvement in the day-to-day running of the centre. They discussed how they take turns chairing the residents' meetings. However, from speaking with a number of residents and reviewing documentation in the centre, it was evident that at times residents did not feel safe in their home. A number of residents informed the inspectors that sometimes they did not get on with all of their peers all of the time and described how sometimes they needed to spend time in other parts of the centre to get away from their peers. This was also documented in risk assessments, residents' daily notes and monthly reports in the centre.

## Capacity and capability

During this inspection, the inspectors reviewed actions identified by the provider following the last inspection to address areas of non-compliance with the regulations. Whilst there was evidence of completion of some of these actions, some remained outstanding.

The governance and management arrangements in place were not building on the capacity of key personnel in the centre. The inspectors found that initially following the last inspection strengthened arrangements were put in place by the provider to monitor the care and support for residents. However, this support was not maintained and concerns remained in relation to the providers' capacity to monitor and oversee the day-to-day management of the centre. These concerns particularly related to safeguarding residents and the review and escalation of incidents. The person in charge was on leave on the day of inspection and therefore some actions

from the previous inspection could not be assessed.

The inspectors found that there were improvements noted in relation to residents' personal plans, risk management, fire management and medicines management in the centre. The provider had sourced expertise from within the organisation to support the staff team in relation to residents' healthcare needs, risk management and medication management.

Whilst there were clearly defined management structures in the centre, the inspectors were not assured that effective oversight arrangements were in place. For a period of time following the last inspection there was evidence of increased monitoring and oversight in the centre for a number of months. However, this decreased when the person participating in the management of the designated centre and their manager retired. A new service manager had been appointed; however, there was almost three months where there was reduced supports available to the person in charge in the centre.

The inspectors reviewed a number of residents' personal plans and other documentation in the centre during the inspection and found information relating to residents not feeling safe in their home. In addition, the inspectors found numerous incidents which had occurred in the centre since the last inspection which potentially met the definitions of abuse as outlined in the Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures (HSE, 2014). In addition, the inspectors found an incident where a resident had gone missing from the centre which had not been reported in line with the requirement of the regulations.

The inspectors reviewed the annual review in the centre in 2017. There was evidence that the input of residents, their families, members of the multidisciplinary team and staff in this review. There was positive feedback in the report in relation to aspects of care and support in the centre. A number of required actions were identified as a result of this review. Whilst there was evidence of completion of some of these actions, some remained outstanding. The latest six monthly review by the provider had not been completed within the timeframe identified in the regulations. When the new service manager commenced in post they completed this review. There was a quality enhancement action plan in place in the centre. On reviewing this document the inspectors found that it was limited to follow up actions from the last inspection. It did not address other important aspects of care and support in the centre such as residents' rights, dignity and consultation, communication, use of resources or maintenance.

Improvements were noted in relation to staff training and supervision. The inspectors reviewed staff training records and found that 100% of staff were now trained in safeguarding. The person in charge had completed support and supervision training. They had a schedule in place and were completing regular formal supervision with staff. The inspectors reviewed a number of staffs' supervision records and topics discussed included keyworker duties, staffs' overall performance and their training needs.

Improvements were also found in relation to rosters and staffing arrangements in

the centre. The inspectors reviewed a number of actual rosters in the centre and found that they clearly identified who was on duty in the centre. They also clearly identified staffing support in place for one resident in the centre during the day. From speaking to the resident and staff it was evident that changes to staffing arrangements during the day was having a positive impact. However, the inspectors found that staffing numbers required review as a sleepover shift had been introduced in one of the houses in the centre which was impacting the availability of staff to cover shifts in the centre.

## Regulation 15: Staffing

The inspectors reviewed rosters in the centre and found that improvements had been made. They clearly stated which staff were on duty and the supports in place for one resident during the day. Some improvements had also been made in relation to the availability of staff in the centre to support residents. However, staffing numbers in the centre required further review due to the fact that a sleepover shift had been introduced in one of the houses in the centre in line with residents' changing needs.

Judgment: Substantially compliant

## Regulation 16: Training and staff development

100% of staff in the centre had now completed safeguarding training and the person in charge had completed support and supervision training. Staff were now in receipt of regular formal supervision which was being completed by the person in charge.

Judgment: Compliant

## Regulation 23: Governance and management

There had been a number of changes to the management structure in the centre since the last inspection. Inspectors found that suitable arrangements were not in place to monitor care and support for residents' in the centre. There had been a period since the last inspection where limited support was available for the person in charge. An annual review had been completed in the centre and an action plan developed. However, there was no evidence of tracking or sign off on some of the identified actions following this review. The six monthly visit by the provider had not been completed in line with the timeframe identified in the regulations. The quality

enhancement action plan in place in the centre was limited to actions following the last inspection and did not include other important aspects of care and support in the centre.

Judgment: Not compliant

## Regulation 31: Notification of incidents

An incident when a resident went missing from the centre had not been reported in line with the requirement of the regulations. In addition, an allegation of abuse which had been reported to the designated officer had not been reported to the chief inspector in line with the requirement of the regulations.

Judgment: Not compliant

## Quality and safety

Inspectors found that some improvements had been made to the quality and safety of the service provided to residents. The provider sourced the expertise from within the organisation to review risk management, residents' healthcare needs and medication management in the centre. However, areas for improvement remained in relation to the oversight of care and support and in recognising, reporting and escalating safeguarding concerns in the centre.

The inspectors found that improvements had been made in relation to residents' assessment of need and personal plans since the last inspection. The person in charge and key workers had met and reviewed residents' assessments of need and personal plans. These reviews were clearly noted in residents' files. The inspectors spoke with a number of residents and found that the goals they described were reflected in their personal plans. It was evident that residents were regularly attending events such as going to football matches, the cinema and comedy shows with their friends.

The director of nursing, a clinical nurse manager and a social care worker from the organisation had completed residents' dependency assessments since the last inspection. A nursing review of each of the eight residents' health care needs had been completed. Residents' health care support plans were updated to correspond with their identified health care needs. Support plans were also updated to include multidisciplinary team notes, plans and recommendations.

The inspectors found that some improvements had been made in relation to incident review and tracking in the centre. Following the last inspection the health and safety manager met with the person in charge to review accidents and incidents and

develop systems to assess trends in the centre including an incident tracker. However, inspectors found that improvement was still required in relation to suitable arrangements for identifying incidents in the centre. This particularly related to an incident when a resident went missing and not recognising and reporting safeguarding concerns in the centre.

There were plans in place to address safeguarding concerns in one house of the designated centre. In the other house staff spoken with stated there were no safeguarding concerns, though there were safeguarding plans in place in this house. The inspectors spoke to a number of staff in relation to these safeguarding plans and they could not ascertain if the appropriate reporting and screening had been completed for this or other allegations of abuse in the centre. However, in this other house inspectors reviewed recent daily notes, spoke with residents and staff and found a number of incidents were not being recognised as potentially abusive interactions, so as a result were not being escalated to the person in charge or designated officer, or reported in line with the requirements of the regulations. Furthermore, although staff had received training in safeguarding staff application of this training required review. For example, an allegation of abuse was only noted as such at a staff meeting, three weeks after the event. Once the person in charge was made aware of the incident they escalated it to the designated officer. The designated officer reviewed the incident in line with the organisations' threshold document and found that it did not require any further action. On reviewing this incident, the inspectors found that it potentially met definitions of abuse.

In order to build staffs capacity and understanding of safeguarding, subsequent to the last inspection, the provider had committed that the designated officer would attend a staff meeting. There was evidence that the person in charge had requested the designated officer to attend a staff meeting in the centre to discuss safeguarding. However, the designated officer did not have availability to attend a staff meeting. There were recognised compatibility issues within the centre and support was being obtained from allied health professionals to support residents within the home on an individual basis.

The restrictive practices in place in the centre had been reviewed since the last inspection. This review had been completed with the input of the internal monitoring group and allied health professionals. The inspectors reviewed residents' positive behaviour support plans and found that they were not all sufficiently detailed to guide staff practice to support residents to manage their behaviour. For example the de-escalation techniques were not clear for all staff.

The inspectors found that improvements had been made to risk management since the last inspection. Risk assessments were reviewed and updated. The person in charge sent all risk assessments to the health and safety manager for review. The risk register was reviewed and updated. However, safeguarding was assessed as being a low risk. This was not in keeping with the findings on this inspection. Risk assessments were added as an agenda item to staff meetings. 'At home' support plans and risk assessments were now in place for a number of residents. However, the inspectors found that one of these required review in line with the resident's

changing needs.

Improvements had occurred in relation to fire management systems. A number of fire drills had been completed since the last inspection. Following a drill a resident's personal emergency evacuation plan was reviewed and updated to reflect the learning from the drill. Fire drills and learning following them were then discussed during the next staff meeting in the centre.

Following the last inspection a review of medication management practices in the centre was completed by the health and medical trainer. Following this review the health and medical trainer attended a staff meeting to discuss medication management policies and procedures including safe storage and self administration risk assessments. They also  also completed a review of procedures relating to as required medicines.

## Regulation 26: Risk management procedures

The provider had sourced the expertise from within the organisation to support the person in charge to review systems in place in relation to risk management. However, the inspectors found that improvements were still required in relation to identifying incidents in the centre.

Judgment: Substantially compliant

## Regulation 28: Fire precautions

Residents had personal emergency evacuation plans in place which had been reviewed and updated in line with learning from fire drills in the centre. Following the last inspection the required emergency light had been installed.

Judgment: Compliant

## Regulation 29: Medicines and pharmaceutical services

A review of medication management practices was completed by the organisations' health and medical trainer. This review included medication management practices including safe storage, as required medicines, and self administration risk assessments.

Judgment: Compliant

## Regulation 5: Individual assessment and personal plan

Residents' assessment of need and personal plans were reviewed since the last inspection.

Judgment: Compliant

## Regulation 6: Health care

The provider had sourced support from within the organisation to complete residents' dependency assessments. Residents' health care support plans were updated to correspond with their identified heath care needs.

Judgment: Compliant

## Regulation 7: Positive behavioural support

The inspectors reviewed records relating to restrictive practices and found that appropriate reviews of all restrictive measures had been completed. On reviewing residents' positive behaviour support plans the inspectors found that they were not sufficiently detailed to guide staff practice to de-escalate behaviour.

Judgment: Substantially compliant

## Regulation 8: Protection

Although all staff had received training in safeguarding vulnerable adults since the last inspection it remained that all forms of abuse were not being recognised as such or responded to appropriately. There were identified and known compatibility issues between a number of residents and it was evident from speaking with residents and reviewing documentation that some residents did not feel safe at all times in their home.

Judgment: Not compliant

**Appendix 1 - Full list of regulations considered under each dimension**

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 15: Staffing | Substantially compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 31: Notification of incidents | Not compliant |
| **Quality and safety** | |
| Regulation 26: Risk management procedures | Substantially compliant |
| Regulation 28: Fire precautions | Compliant |
| Regulation 29: Medicines and pharmaceutical services | Compliant |
| Regulation 5: Individual assessment and personal plan | Compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Positive behavioural support | Substantially compliant |
| Regulation 8: Protection | Not compliant |

# Compliance Plan for Clew Bay OSV-0002334

## Inspection ID: MON-0024542

## Date of inspection: 16/08/2018

### 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:**

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 15: Staffing</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 15: Staffing:<br><br>• Regulation 15. (1). Roster review is scheduled for the 12/10/18 by the Person in Charge, Service Manager, Administrator and the HR manager to ensure the provision of consistent staffing with suitably qualified staff for the centre.<br><br>• The Person in Charge will ensure that the monthly roster reflects the needs of the residents.<br><br>• All documentation specified in schedule 2 are maintained by the HR department and available to review on request.</td></tr>
<tr><td>Regulation 23: Governance and management</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management: A review of Management systems will be taken by the Registered Provider.<br><br>• The designated centre will continue to be resourced to ensure all residents' support needs are met in accordance with the statement of purpose.<br><br>• There is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability. A new Service Manger was appointed on the 16/7/18 to support the Person in Charge and the organisation has appointed a new Director of Adult Services as from the 10/09/2018 to service area 1<br><br>• Regulation 23 (1) (c): Quality and safety governance management systems will be reviewed by the Service Manager and the Director of Adult Services and monthly data reports will be introduced to the designated centre to ensure that the service provided are safe, appropriate to residents' needs, consistent and effectively monitored.</td></tr>
</table>

- Theses monthly data reports will be completed every 4 weeks by the PIC and submitted to Service Manager for discussion at the support meetings, this process will ensure the effective communication of all concerns, actions and escalation if warranted.

- 6 weekly formal support meetings have been scheduled with the Service Manager and the PIC

- Regulation 23(2)(a). Six monthly unannounced visits are completed in the centre. These reports are contained in the centre and are available for review and an additional unannounced visit will take place in the centre.

- The Quality Enhancement Plan (QEP) will be reviewed and updated by the PIC for the centre and this will allow the PIC and Service Manager to monitor progress of all internal and external actions needed to improve the quality and safety of service provision.

- Regulation 23(3)(a): The PIC will receive 6 weekly supervision meetings with the Service Manager with a set agenda in relation to the governance and management of the centre.

| Regulation 31: Notification of incidents | Not Compliant |
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Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

- Regulation 31(1)(e) Outstanding notification of the unexplained absence of a resident has been submitted to the authority retrospectively on the 27/8/18 and support plans have been updated for the resident.

  Regulations 31(1)(f) Notification of any allegation, suspected or confirmed, of abuse of any resident will be submitted to the authority.

- The Service Manager will attend the staff meeting on the 10/10/18 to discuss and review all 3 day notifications with the staff team.

- The PIC will ensure that all required notifications will be sent to the authority in the required time frame.

| 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:

- There is a Risk Management policy is place. St Michaels House are updating the Risk Management Policy to reflect changes in assessment of risk including methodology, updating of risk assessment template and risk register template to ensure that significant risks are sufficiently managed, tracked and reviewed for effectiveness. Revised policy will be brought at Quality Safety Executive Committee for discussion in October 2018.

- The PIC is trained in the management of risk and will continue to develop systems in the centre for the assessment, managements and ongoing review of risk, which include a system for responding to emergencies.

- Regulation 26.(2): A review of all designated centre risks and proportionate risk allocation will be completed on the 10/10/18 with the PIC, Service Manager, Senior Social Worker and SMH HIQA Officer. This process will include a review of safeguarding plans to ensure it reflects actual risk and control measures.

- Quality and safety governance management systems will be reviewed by the PIC and Service Manager and monthly data reports will be introduced to the designated centre to ensure that the service provided are safe, appropriate to residents' needs, consistent and effectively monitored.

- Theses monthly data reports will be completed every 4 weeks by the PIC and submitted to Service Manager for discussion at the support meetings, this process will ensure the effective communication of all concerns, actions and escalation if warranted.

- 6 weekly formal support meetings have been scheduled with Service Manager and PIC

- The submission of Monthly data quality and safety reports from the PIC to the Service Manager will ensure appropriate risk are assessed, managed and escalated where required and the PIC and Service Manager will respond to all emergencies.

- The Service Manager will complete another six monthly unannounced visits to the centre and review all accidents and incidents in the centre in order to identify any trends and agree actions to prevent further occurrence as appropriate.

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

- Regulation (5)(a). The Centre's Senior Clinical Psychologist will review the Psychological Support Plan to ensure it identifies the cause of the residents behaviours and how best to support the de-escalation of behaviours will be completed on 19/9/18

| Regulation 8: Protection | Not Compliant |
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Outline how you are going to come into compliance with Regulation 8: Protection:

- Regulation 8. (2). Senior Social Worker will attend a staff meeting in the centre on the 10/10/18 to ensure all staff are able to recognise and report on all forms of abuse.

- A reporting protocol is in place to ensure all safeguarding concerns are reported to Principal Social Worker and Service Manager. The protocol will be discussed with the staff team on the 10/10/18. A recording of all themes will also be captured on

a separate report sheet in Residents active file.

- Service Manager and PIC will discuss regularly any themes or trends, which will be reflected in the management minutes and reported to Principle Social Worker

- The PIC, Service Manager and the Senior Social Worker will review and update all individual safeguarding plan's for the safety and protection of residents in the centre and this will be completed and discussed on the 10/10/18

- The agenda for key- worker and key-client meetings will now reflect discussion in relation to their safety.

- The senior clinical psychologist will carry out a work shop with the residents in the centre in supporting them to develop skills so that they have knowledge and skills to promote their personal self-care and protection.

- Safeguarding will be a set agenda on the staff team meeting.

## 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 15(1) | The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre. | Substantially Compliant | Yellow | 12/10/18 |
| Regulation 23(1)(c) | The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. | Not Compliant | Orange | 30/10/18 |
| Regulation 23(2)(a) | The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support. | Not Compliant | Orange | 30/10/18 |

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|---|---|---|---|---|
| Regulation 23(3)(a) | The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering. | Not Compliant | Orange | 30/10/18 |
| 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 | 10/10/18 |
| Regulation 31(1)(e) | 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 unexplained absence of a resident from the designated centre. | Not Compliant | Orange | 27/8/18 |
| 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. | Not Compliant | Orange | 20/9/18 |
| Regulation 7(5)(a) | The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour. | Substantially Compliant | Yellow | 19/9/18 |
| Regulation 08(2) | The registered provider shall protect residents from all forms of abuse. | Not Compliant | Orange | 10/10/18 |