Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of designated centre:	Teach Gairdeach
Name of provider:	St Hilda's Services Limited
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	13 September 2018
Centre ID:	OSV-0005721
Fieldwork ID:	MON-0024016

About the designated centre

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

Teach Gairdeach designated centre run by St. Hilda's is equipped to provide residential services for 6 residents. Services are provided for adults of a mixed gender whose primary diagnosis is an intellectual disability who have a level of independence as such waking night cover is not required. Teach Gairdeach is a 5 day service opened from Monday to Friday, on weekends residents return home to their families. Residents attend day services during the day and in cases of short term illness arrangements are made for residents to return home. The service has fixed closures in line with the operations of the day service. Teach Gairdeach is an extended bungalow building which consists of 6 double bedrooms all with ensuite bathrooms and showers. There is a separate living room area, kitchen and dining area with a dedicated area for activities. Residents avail of organised transport for day services and local bus services and taxis are used outside of these times.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
13 September 2018	09:00hrs to 15:00hrs	Erin Clarke	Lead

Views of people who use the service

The inspector met with four residents briefly before they went to their day services, residents told the inspector that they were going to a football game after their day services and they would not be back until late evening, and that they were excited about going to the game. One resident showed the inspector around the house and their bedroom, as the centre was recently opened they told the inspector what they had chosen for their bedroom and how much they liked the new house. The inspector observed other residents finishing their morning routines getting ready to go on the bus. All residents appeared very at ease with staff and happy to leave for their day services.

Capacity and capability

This centre had recently become operational in May 2018 as a designated centre for four residents; who had transitioned from another St Hilda's designated centre. The size, layout, design and facilities contained within this centre afforded itself to provide a high quality service to residents. There was evidence that the residents were informed and involved in the transition of services. The inspector found that significant improvements were required to ensure that an effective, appropriate and safe service was continuously delivered to residents through an effective governance structure.

Prior to the inspection the provider had notified the Authority that the person in charge would be absent for a prolonged duration, this notification was not submitted within the required time frame. Due to the broad remit and governance responsibilities of the proposed person in charge the Authority issued an assurance report to the provider to provide their assurances that the arrangements in place were appropriate to ensure effective oversight of the designated centre. One of the aims of this unannounced monitoring inspection was to confirm that the arrangements in place were appropriate in meeting the needs of the residents. The inspector found challenges were present in the oversight of systems and processes including the monitoring and on going review of service care provision. It was identified that the persons' in charge broad range of current responsibilities outside of the designated centre had not afforded them the capacity to be involved in the day to day operation of the centre. This was evident in the improvements identified for the delivery of staff supervision, management of risk, reviewing the changing needs of residents, knowledge of their healthcare requirements and completing actions identified in audits. During the course of the inspection the person in charge and the provider discussed potential plans

to strengthen the current governance structure.

The inspector identified good areas of practice through audits carried out by a nurse employed within the organisation in the areas of medication management and environmental infection control. These audits identified a number of gaps and pertinent areas for improvement, however the action plan was not delegated to any one person and time lines for completion were not included. The person in charge did not have oversight of these audits and was unaware of the status of the outstanding actions. Additionally as the designated centres in the organisation were randomly selected for auditing it was unknown when the next audit would occur to ensure actions were completed and followed up. Two centres were selected for random auditing on an annual basis, this meant it could be four years before this designated centre was audited again. This practice did not demonstrate a sufficient oversight of the service by the current governance structure. Whilst self audits were taking place in the centre on a quarterly basis by staff and the person in charge these were not as robust or thorough in recognising issues as identified by the nursing audit.

The statement of purpose is a key governance document which the designated center is registered against and the provider is responsible for keeping up to date. This document was reviewed during the inspection and was found to be missing some of the key information. The inspector found that the statement of purpose did not accurately reflect the service delivered to residents, it did not highlight that the service faced planned closures totalling 29 days in the year, it also did not reflect the residents contract of care in relation to payment of fees for taxis. The person in charge full time equivalent was not accurate as it did not reflect the time required for the dual role of residential service manager. From discussion with the person in charge it was apparent that they were not based in the centre or were involved in the day to day operations of the centre.

The registered provider had systems in place to ensure the implementation of an annual audit of service and care provision and unannounced six monthly visits. These had not yet been completed as this was a new centre which commenced operations. Improvements were identified in the annual review template to ensure that the quality and safety of the centre was captured as the template was generic and not specific to the centre

The provider had made arrangements for the allocation of adequate staffing levels to support residents. An actual and planned rota was developed and maintained in the center which reflected the statement of purpose. A training matrix reviewed by the inspector identified that all staff had completed mandatory training. The inspector met with one staff member during the course of the inspection and they demonstrated good knowledge of the systems in running the designated centre and the needs of the residents. The inspector reviewed the minutes of staff meetings that occurred on a monthly basis which discussed set agenda items such as health and safety, risk, and safeguarding issues. Within the minutes it was recorded that the person in charge communicated to staff that safeguarding incidents did not have to be notified to the authority when a behavioural support plan was in place. The inspector brought this to the immediate

attention of the person in charge and provider at feedback to clarify that all safeguarding concerns had to be notified as required by the regulations.

Improvements were required in the monitoring and supervision of staff to ensure that they were being effectively supervised relevant to their roles and responsibilities. Supervision was taking place during team meetings with another designated centre, this was not in line with best practice environment to discuss individual staff in a group setting to foster effective supervision practices as no other form of supervision had occurred.

A new tenancy agreement had been signed since residents moved into the designated centre but the agreement did not identify the designated centre and there was incorrect information contained within. It stated that staff members were insured to drive their own vehicles as transportation for residents but it was found that none of the staff identified on the roster as having this indemnification. It did not reflect the planned closures in the centre.

Written operational policies and procedures were reviewed and up to date. A written directory of residents was in place but this had not been reviewed since residents had transitioned so the details contained within did not reflect the current designated centre.

Regulation 14: Persons in charge

The person in charge whilst possessed the necessary experience and knowledge to meet the regulatory requirements they did not have the capacity to fulfill their legal responsibilities.

Judgment: Not compliant

Regulation 15: Staffing

Planned and actual rosters were maintained in the centre. From reviewing these rosters and talking to staff members present, inspectors were satisfied that there was a continuity of staffing provided for residents. A sample of staff files were reviewed and found to contain all of the required information as per schedule 2 of the regulations.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had received relevant training relevant to their roles but were not in receipt of appropriate supervision.

Judgment: Substantially compliant

Regulation 19: Directory of residents

An up to date directory of residents had not been maintained in the centre.

Judgment: Not compliant

Regulation 23: Governance and management

Whilst audits were occurring in the service, these had not been delegated to a person responsible for completion of actions and self audits completed in the centre were not sufficiently robust.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The contract of care in place did not list the closures that occur in the centre and provided inaccurate information for transport options.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose did not accurately reflect the services provided for

the resident nor was it updated for the change in person in charge and management structure.

Judgment: Not compliant

Regulation 32: Notification of periods when the person in charge is absent

The provider did not notify the authority within one month of the proposed absence of the person in charge.

Judgment: Not compliant

Regulation 4: Written policies and procedures

All schedule 5 policies were present and reviewed within the relevant time lines.

Judgment: Compliant

Quality and safety

Poor oversight and response was found in key areas of service provision to support residents on an individual basis in line with their assessed needs. The inspector found significant improvements were required to ensure residents were fully supported and in receipt of a safe and quality driven service.

The inspector found that an assessment of need and personal plan had not been developed for each resident and that there was no established care planning system in place which incorporated an assessment of needs from which care plans and interventions were developed, reviewed and evaluated. Records that had transitioned with the residents were out of date, contained gaps in pertinent information and did not have details of the health care needs of the service user as identified by the inspector during the inspection. Through a review of the documentation the inspector found incomplete information relating to high blood pressure, abnormal blood tests, scoliosis, falls risk, swallow risk, thyroidism and urinary investigations; these were unknown to the person in charge and lacked a corresponding support plan to guide staff; or scheduled follow ups and reviews. It

was unclear and unknown what referrals or appointments had occurred with speech and language therapists, physiotherapists, dentists and opticians although this had been identified as a requirement for some residents. It was communicated to the inspector from the provider that the onus of facilitating health care appointments was with the families of the residents due to the service being a five day service. This was deemed a contravention of the regulations and presented as a high risk in the designated centre. The inspector was not ensured that changes in health, personal circumstances and profile of the residents were being reviewed to ensure that a five day service provision with fixed closures was appropriate to meet the needs of all residents that availed of its services. The process to assist residents achieve optimum health and development required significant improvements to ensure the health and development of residents was achieved.

The provider had implemented an online incident recording system that delegated completed incident reports to the person responsible for risk rating the incident and completing any identified actions. This facilitated the trending and tracking of incidents for potential learning opportunities. Individual risk assessments had been completed for residents since moving into centre but not all risks present were identified, risk rated or effective control measures put in place. For example a falls risk assessment had not been completed for a resident that received a fracture from a fall and choking risk assessments were not in place for residents identified with feeding, eating or drinking difficulties. The provider had in place a risk management policy but it was found to be missing critical information regarding the identification, recording and investigation of incidents or adverse risks involving residents.

On inspection of the centre no restrictive practices were in use and it was reported to the inspector that there was no behaviours of concern and that no behavioural support plan were required or in use. A review of the positive behavioural support policy found that it required revision to ensure that it reflected best practice. A reference within the policy on the possible use of suspension from the centre was deemed to impinge on the rights of the resident and was found not to be in line with the admission policy and contract of care.

The designated centre was purpose built and was suited to meet the needs of residents both in terms of space, accessibility and facilities available. The centre was spacious and presented in a homely manner and bedrooms had been personalised based on the individual preferences of residents. An adequate number of bathroom facilities were provided along the other regulatory requirements such as suitable storage, a separate kitchen area and communal space. The outdoor space required maintenance to afford residents the option to access the garden area.

The inspector noted that the centre had appropriate and suitable practices relating to the ordering, receipt, prescribing, storage, disposal and administration of medicines. Staff were knowledgeable and competent to administer medication with all staff medication management training up to date. The inspector could not review a sample of prescription and administration records as part of the inspection as

these records went with the residents to day services.

The inspector found that the provider had implemented effective fire safety management systems and there was adequate precautions for the detection, containing and extinguishing of fires. There was evidence that fire drills had taken place in the service identifying the various emergency exits that were to be used by residents whilst in their bedrooms. Personal emergency evacuation plans had been developed for all residents.

Regulation 17: Premises

The inspector observed that the resident's home was maintained to a high standard and was warm and homely. Areas that required improvement included the outdoor area which required significant maintenance.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The centre had an established risk management system in place for the recording of incidents however the risk management system did not identify all risks in the centre and the risk management policy, did not include all required elements as outlined in the regulations.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Suitable fire prevention and fire fighting equipment were in place and serviced as required.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The inspector noted that the centre had appropriate and suitable practices relating to the ordering, receipt, prescribing, storage, disposal and administration of medicines.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

A comprehensive assessment of the health, personal and social care needs of each resident which reflects the assessed needs and outlines the supports required had not been carried out.

Judgment: Not compliant

Regulation 6: Health care

The healthcare needs of the residents were not being managed, promoted or maintained by the provider as required by regulations.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Improvements were required for the use of restrictive practices as detailed in the positive behavioural support policy to ensure that it was in line with best practice.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 32: Notification of periods when the person in charge is absent	Not compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
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	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant

Compliance Plan for Teach Gairdeach OSV-0005721

Inspection ID: MON-0024016

Date of inspection: 13/09/2018

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**
Regulation 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: A New Person in Charge was been appointed 20/9/18 and documentation posted 18/10/18 – currently in process.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Individual Supervision meeting completed 6/11/18.	
Regulation 19: Directory of residents	Not Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: The Directory of residents has been brought in to compliance by including the next of kin for 1 resident which had been omitted 6/11/18.	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The management structure of the centre has been revised to reflect the reporting system. The provider has commissioned an external organisation to conduct 6 monthly audits(5th – 27th November) to ensure quality and safety of care and to give effect ot greater capacity within management system. The Provider will revise the approach to Internal Audit in terms of effectiveness and detail be provision of mentor to Residential manager.

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
The Contract of Care & Statement of Purpose and Function is currently under revision. A further consultation with families/residents is planned for 21/11/18. The process of engagement re changes will conclude in 12/12/18.

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The Contract of Care & Statement of Purpose and Function is currently under revision. A further consultation with families/residents is planned for 21/1118. The process of engagement re changes will conclude in 12/12/18.

Regulation 32: Notification of periods when the person in charge is absent	Not Compliant
Outline how you are going to come into compliance with Regulation 32: Notification of periods when the person in charge is absent: The incident was reported retrospectively under Regulation 31(1)(f) on 13/9/18. A review of the prior quarter (3rd quarter) incidents will be completed and where necessary a written report provided, this will be completed by 16/11/18	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The back garden will be reseeded in spring. 16/2/19	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The Risk Management policy has been revised accordingly and is scheduled for Board approval 13/11/18	
Regulation 5: Individual assessment and personal plan	Not Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: All families have received a letter outlining the requirements for Annual Health Assessment All annual health, personal & social care plans have been reviewed and updated. All PCP review meetings with families and individuals have been held to assess social, personal supports and set goals 30/11/18. Where additional needs or observations have been identified i.e eating or swallow referrals for assessment and future care planning are now being requested and followed up. The Nurse for service will review	

health needs and up-dated care plan to ensure they are meeting needs of resident 5/12/18.

Regulation 6: Health care	Not Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: Al l families have received a letter outlining the requirements for Annual Health Assessment and the PIC has ensured all Annual Health Personal Plans have been reviewed and up-dated. The follow on care required will be put into care plan and reviewed by the Nurse for Services to ensure it meets needs identified Health Professional (to be completed by 5/12/18).	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The policy has been amended to remove "Suspension". The amended policy is for Board approval 13/11/18.	

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 14(2)	The post of person in charge shall be full-time and shall require the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.	Not Compliant	Orange	18/10/2018
Regulation 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated	Not Compliant	Orange	18/10/2018

	centres concerned.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	16/11/2018
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	06/02/2019
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	06/02/2019
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Not Compliant	Orange	06/11/2018
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	06/11/2018
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the	Substantially Compliant	Yellow	06/11/2018

	designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
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 charged.	Not Compliant	Orange	12/12/2018
Regulation 24(4)(b)	The agreement referred to in paragraph (3) shall provide for, and be consistent with, the resident's needs as assessed in accordance with Regulation 5(1) and the statement of purpose.	Not Compliant	Orange	12/12/2018
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	13/11/2018
Regulation 03(1)	The registered	Not Compliant	Orange	12/12/2018

	provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.			
Regulation 32(2)(a)	Except in the case of an emergency, the notice referred to in paragraph (1) shall be given no later than one month before the proposed absence commences or within such shorter period as may be agreed with the chief inspector and the notice shall specify the length or expected length of the absence.	Not Compliant	Orange	16/11/2018
Regulation 05(1)(a)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.	Not Compliant	Orange	05/12/2018
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	05/12/2018

Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	05/12/2018
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Not Compliant	Orange	05/12/2018
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Not Compliant	Orange	05/12/2018
Regulation 05(4)(c)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the	Not Compliant	Orange	05/12/2018

	resident which is developed through a person centred approach with the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.			
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	05/12/2018
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	13/11/2018