Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Antoine House
Name of provider:	Health Service Executive
Address of centre:	Monaghan
Type of inspection:	Short Notice Announced
Date of inspection:	23 September 2020
Centre ID:	OSV-0005751
Fieldwork ID:	MON-0030170

About the designated centre

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

Antoine House is a large detached bungalow situated in a large town in County Monaghan. The property was purpose built by a parents and friends association. The property is leased by the Health Service Executive (HSE). Five residents live in this community home and are supported by a nurse led team 24 hours a day. Each resident has their own bedroom with en suite facilities. The property is spacious and modernised with a large garden to the rear of the property. Most of the residents attend day services in the community and one resident is being supported using the new directions model of care in order to provide meaningful day activities during the day. There is a full time person in charge in the centre who is a qualified nurse. Transport is provided in the centre so as residents can avail of community facilities if they wish.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 23 September 2020	10:40hrs to 16:50hrs	Caroline Meehan	Lead

What residents told us and what inspectors observed

The inspector was introduced to four of the residents on the morning of the inspection and spent time talking to two of the residents during the day. The inspector also briefly met another resident on the afternoon of the inspection. On the morning of the inspection one resident was attending day services and another resident was supported to go to the local shop to purchase items of his choice. On return, the inspector met this resident and he gestured to the items purchased, while the staff supported him to explain his daily routine and preference of going to the shop daily. It was evident that staff know the resident's individual communication method well, and as such were able to support him to facilitate his communicative intent. For example, the resident indicated he wanted to use the computer and staff facilitated this.

Staff were observed to provide care in a supportive and caring way, taking into account the individual needs of residents. It was evident that the staff knew the residents well and residents appeared comfortable and happy in their environment. However, given the support requirements of residents, and the staffing levels in the centre, opportunities for residents to engage in meaningful activities were limited. Staff expressed a concern that activities were limited for residents due to staffing levels, and opportunities for residents to be supported in community engagement, skills development and a varied day were not possible. The inspector observed this to be the case on the day of inspection whereby a resident asked twice what she was doing today and when she was going out, however staff outlined to the inspector this would most likely be limited to a bus drive later in the afternoon due to staffing levels. Similarly, there were times when the basic supervision levels of residents could not be maintained, resulting in poor practices, which had the potential to impact the safety and wellbeing of residents in the centre.

The inspector met with one family member at the beginning of the inspection, who outlined overall they were happy with the care and support provided to their relative in the centre. The family member was complementary of the person in charge and the staff in the centre, and stated they were approachable and acted upon requests from the family in relation to care and support of their relative. The family member outlined one concern they had in relation to the welfare of their relative, and the inspector found the provider had initiated actions to consider this concern.

Capacity and capability

The governance and management arrangements in the centre had not ensured the delivery of safe and effective services, consistent with residents identified needs.

Improvement was required to ensure the care and support was appropriately and comprehensively monitored to determine compliance with regulations and best practice, with timely improvement plans developed and implemented.

The provider had not resourced the centre to ensure the effective delivery of care and support to residents, and consequently practices relating to the implementation of restrictive practices, supervision and meaningful activation for residents, and aspects of emotional care needs were not safely or appropriately implemented. There were insufficient staff numbers employed in the centre to meet the specified support levels as identified in personal plans and risk assessments. For example, three residents required 2:1 staff to leave the centre for an activity however, as there were only four staff on duty daily, this meant only one of these residents could leave the centre at any one time. The inspector observed this to be the case on the day of inspection, where one resident was being supported by two staff to attend an appointment, therefore none of the remaining four residents could leave the centre during the afternoon period. Two staff confirmed that due to staffing resources there were limited opportunities for residents to engage in meaningful activities either in or outside of the centre.

Similarly, residents had supervision and support levels when in the centre, specified in accordance with their needs, and in some cases as part of safeguarding plans; however, the inspector observed this could not be maintained for the residents at all times. For example, one resident required 1:1 staffing at all times, which left one staff to supervise three residents, one of whom was observed to leave the centre unaccompanied during the inspection.

The provider had nominated a representative to complete six monthly unannounced visits in the centre. Residents had been met and their opinions sought as part of these visits. The inspector reviewed the reports of the two most recent unannounced visits. A number of areas of care and support were reviewed as part of this visit; however, the inspector found the review of restrictive practices in the centre was not comprehensive and an environmental restrictive practice had not been reviewed. Poor practice was found on this inspection relating to the use of this restriction, and the inspector found the opportunity for the provider to highlight and address concerns on the safety and quality of this practice was not implemented. While an overall review of restrictive practices in the centre had been completed in August 2020, one action had been identified relating to staffing resources for one hour a day; however, this had not been completed by the provider on the day of inspection. An action plan had been developed for those areas of concern identified during the unannounced visit and actions were found to be completed on the day of the inspection.

The provider had notified HIQA of a number of restrictive practices in use in the centre. However, the use of window restrictors throughout the centre had not been notified to HIQA, as required on a quarterly basis.

An annual review of the quality and safety of care and support had been completed in June 2020 and the outcome of the unannounced visits to the centre formed part of this review. A number of actions had been developed following the review;

however, the time frame for implementing these actions was not consistently specified. The inspector reviewed a sample of actions and found some actions had been completed however, some actions were not complete with no specific time frame to complete these.

The person in charge maintained a quality improvement plan for the centre, and a number of actions reviewed on the day of inspection were found to be completed within the specified time frame.

There was a full-time person in charge employed in the centre and staff stated they felt supported by the person in charge. The inspector found the person in charge knew the residents well and was knowledgeable on individual resident's support needs and plans. Two staff members outlined to the inspector that they could raise concerns about the quality and safety of care and support provided to residents with the person in charge, should the need arise. The inspector reviewed two staff supervision records and found this process allowed for a review of staff members performance, with actions developed to enable staff to deliver support and care in line with service policy and guidelines.

Planned and actual rosters were reviewed by the inspector and found to be maintained appropriately. Four staff were on duty during the day and two staff at night time. Nursing care was provided in accordance with the statement of purpose and the residents' assessed needs. Consistent staffing was provided; however, as outlined, the number of staff on duty was not safe or appropriate to residents' needs. Assurances were sought from the provider on the day of inspection regarding staffing levels in the evening and part of the night-time on weekdays, and during the day time and part of the night time at weekends. The provider gave assurances on the day after the inspection that an additional staff member would be provided from that day on, from 14.00 to 22.00 hrs Monday to Friday, and from 10.00 – 22.00 hrs at weekends.

Regulation 15: Staffing

Consistent staffing was provided and nursing care was also provided in accordance with the statement of purpose and the assessed needs of residents. Planned and actual roster were maintained appropriately.The number of staff on duty was not appropriate or safe in accordance with the assessed needs of residents. Assurances were sought from the provider in relation to the staffing levels in the centre.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had not resourced the centre to ensure the effective delivery of care and support to residents, and consequently practices relating to the implementation of restrictive practices, supervision and meaningful activation for residents, and aspects of emotional care needs were not safely or appropriately implemented.

Monitoring of the care and support provided to residents required improvement to ensure comprehensive auditing practices were implemented. The actions arising from practice reviews were not consistently implemented by the provider or in some cases did not specify the timeframe for completion.

Arrangements were in place for staff to raise concerns about the quality and safety of care and support provided to residents should the need arise. Staff supervision facilitated a review of staff performance, with actions developed to enable staff to deliver support and care in line with service policy and guidelines

Judgment: Not compliant

Regulation 31: Notification of incidents

Quarterly notifications had been submitted to HIQA in respect of a number of restrictive practices in use in the centre; however, the use of window restrictors throughout the centre had not been notified to HIQA.

Judgment: Substantially compliant

Quality and safety

The inspector found that while residents were protected from risks related to safeguarding and infection control, the use of restrictive practices in the centre was not in line with best practice and presented in itself a risk of misuse or overuse. This was a result of poor oversight of some practices and a lack of sufficient resources to ensure restrictive practices were managed appropriately and proportionately to the risk presented.

This inspection was initiated following receipt of information through provider notifications. A number of restrictive practices had been notified to HIQA. The inspector reviewed documentation pertaining to some restrictive practices in the

centre. The inspector found there was poor practice in the implementation and oversight of an environmental restrictive intervention. The practice was found to be implemented on occasions, inconsistent with agreed protocols, and staff spoken with were also inconsistent with the rationale for it's use. Records pertaining to the rationale for use of the restrictive practice, and strategies used to support de-escalation, were also not recorded in nursing notes as per the agreed protocol.

On a number of occasions, the rationale had been identified as observation, however, the person in charge and staff members confirmed observations notes were not maintained when this restrictive practice was applied. Additionally, the conditions for use of this practice was to maintain observation, however, the rationale for use had been recorded at times as inadequate staffing levels, and peers requiring care, consequently there was insufficient staffing to maintain observations. The inspector was not assured given the rationale provided and lack of comprehensive records, that the restrictive practice was applied for the shortest duration. Of the 12 records reviewed, the duration ranged from 10 minutes to 90 minutes. Evidence was not available to confirm if consent had been received from the resident's representative in relation to that restrictive practice. However, following the last inspection, the person in charge had communicated the use of the remaining restrictive practices to the resident's representatives in the centre in July 2019.

Behaviour support plans were in place for residents where required, and residents could access the support of a psychologist and clinical nurse specialist in behaviour. The inspector reviewed one behaviour support plan, which outlined the behaviour of concern, and the proactive and reactive strategies to support the resident with their emotional needs. However, it was not clear from the behaviour support plan when restrictive practices were to be implemented. The behaviour support plan was implemented in tandem with a specific health care plan; however, given the staffing levels, elements of the healthcare plan relating to access to meaningful engagement for the resident, could not be implemented. A protocol relating to the use of environmental zoning had not been updated following a review in August 2020. This was discussed with the person in charge. An updated protocol was made available by the end of the inspection. Staff were knowledgeable on the use of this protocol as per the updated guidance. The inspector reviewed the training matrix and found four staff required up to date training in behaviour that is challenging.

The centre had submitted a number of notifications relating to safeguarding concerns in the centre. The inspector reviewed documentation and spoke to two staff members regarding these risks. The person in charge had initiated an investigation following the occurrence of safeguarding incidents, and all incidents had been reported to the relevant personnel. Safeguarding plans had been developed, and outlined those actions the provider was taking to ensure residents were safeguarded. Additional recommendations made by the Health Service Executive (HSE) safeguarding and protection team were also implemented. For example, a compatibility assessment of residents in the centre had been recommended and the inspector reviewed a draft report completed following this recent assessment. Staff were knowledgeable on the types of abuse, the safeguarding risks in the centre, and on the measures in place to protect residents

in the centre. Staff had received training in safeguarding and in the prevention, detection and response to abuse, and refresher training was planned within the required time frames.

The inspector reviewed a personal plan and found an up to date assessment of need had been completed of the health, social and personal care needs of the resident. The assessment of need was updated throughout the year to reflect changing needs and assessments completed by allied healthcare professionals. Personal plans were developed for those needs identified following assessment, and guided practice in the delivery of care and support for the resident. There was evidence that personal plans were reviewed regularly to assess their relevance to the resident's current needs and to reflect recommendations following reviews.

The inspector reviewed risk assessments developed following identification of individual risks. Risk management plans specified those control measures in place to minimise the risk identified, and the inspector found some of these control measures were implemented. However, some control measures could not be implemented. For example, the control measures outlined in response to aggression and violence could not consistently be implemented, due to a lack of sufficient staffing numbers. In one case a risk management plan required review to reflect the current control measures in place.

Suitable measures were in place relating to the prevention and control of infection. Adequate personal protective equipment (PPE) was provided in the centre. Suitable hand washing facilities and equipment was provided. Staff were observed to adhere to public health guidance relating to social distancing and the use of protective face masks when required. Suitable procedures were in place relating to visitors to the centre including records of all visitors to the centre, the use of PPE and symptom checkers. Personal plans had been developed for residents relating to the care and support in the management of COVID-19. The inspector reviewed the training matrix for the centre and found all staff had up-to-date training in hand hygiene and infection control.

Overall the premises was clean and well maintained and there was adequate communal and private space for residents' use. Painting of parts of the premises had been completed as identified in the providers' six monthly unannounced visit to the centre. Since the last inspection, the centre had been reconfigured to meet specific support needs identified. However, appropriate storage was not provided for a resident's clothing, and a chest of drawers for this resident also required repair.

Regulation 17: Premises

Overall the premises was clean and well maintained and there was adequate communal and private space for resident use. Reconfiguration of the centre had

been completed as required since the last inspection.

However, appropriate storage was not provided for a resident's clothing, and a chest of drawers for this resident also required repair.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Individual risks in the centre had been identified and assessed, and risk management plans outlined the control measures to be implemented to minimise these risks. However, some control measures could not be implemented. For example, the control measures outlined in response to aggression and violence could not consistently be implemented, due to a lack of sufficient staffing numbers. In one case a risk management plan required review to reflect the current control measures in place.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Suitable measures were in place relating to the prevention and control of infection. Sufficient PPE was provided, as well as appropriate hand washing facilities and equipment. Appropriate practices relating to social distancing, and the use of PPE by staff and visitors to the centre, were observed to be in place. Staff had been provided with up-to-date training in hand hygiene and infection control.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Assessment of the health, personal and social care needs of residents had been completed and included the assessment findings of allied health care professionals. Assessments were updated in line with residents' changing needs. Personal plans were developed and guided practice in the care and support for residents. Personal plans were subject to regular review an updated as required in line with the changing needs of residents.

Judgment: Compliant

Regulation 7: Positive behavioural support

Restrictive practices were not applied in accordance with best practice, specifically relating to the implementation, observation and recording of practices consistent with agreed protocols. The inspector was not assured that an environmental restrictive practice was implemented for the shortest duration and that all alternative measures had been applied to reduce the length of time the practice was applied. Evidence was not available to confirm the resident's representative had been informed of this practice.

Behaviour support plans were developed where required, however, the use of a restrictive practice was not clearly set out in a behaviour support plan. The measures outlined in a healthcare plan to support a resident with their emotional needs could not be implemented due to inadequate staffing resources. Four staff had not been provided with up-to-date training in behaviour that challenges.

Judgment: Not compliant

Regulation 8: Protection

Suitable measures were in place to protect residents in line with identified safeguarding risks. Incidents relating to safeguarding concerns had been appropriately reported and investigated, and safeguarding measures were implemented as per safeguarding plans. Staff were knowledgeable on the types of abuse, safeguarding risks in the centre, and on the control measures outlined in safeguarding plans. Staff had received training in safeguarding and in the prevention, detection and response to abuse.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Antoine House OSV-0005751

Inspection ID: MON-0030170

Date of inspection: 23/09/2020

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: In order to meet compliance with Regulation 15: Staffing the following action has been undertaken: The roster at Antoine House has been reviewed to ensure its meets the assessed needs of residents. From the 24/09/2020 one additional staff member is working from 14:00 to 22:00 Monday to Friday and 10:00 to 22:00 on a Saturday and Sunday.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: In order to meet compliance with Regulation 23: Governance and Management the following actions have been undertaken: Staffing levels have been increased from the 24/9/2020 to ensure effective delivery of care and support is provided to residents. All actions identified through the centres auditing process have been completed and/or placed on the centre's QIP with an agreed timeframe for completion. All Person Centred Plan review meetings have been completed as follows: 30/9/2020 ,1/10/2020 and the 6/10/2020, with family/next of kin involvement recorded Update 06/11/2020;	

Additional staff has been provided for this service from 25/09/2020. Since there introduction the level of restrictions imposed on all residents has significantly reduced and in particular in relation to one resident.
This centres Quality Improvement Plan will now be monitored through the General Mangers Office from 06/11/2020 in conjunction with the Registered Provider and Regional Director of Nursing. This monitoring will include on a weekly basis the plan set out under Regulation 7 in relation to securing a bespoke package of care for one resident.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
In order to meet compliance with Regulation 31: Notification of incidents the following action has been undertaken:

Window restriction have been included within the Quarterly Notifications submitted to HIQA on the 20/10/2020 and will continue to be returned as a restrictive practice.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
In order to meet compliance with Regulation 17: Premises the following action has been undertaken:

New wardrobe and chest of drawers has been ordered and will be delivered to centre 23/10/20.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
In order to meet compliance with Regulation 26: Risk Management Procedures the

following actions have been undertaken:

Additional staffing has been implemented within Antoine House from the 24/09/2020, to ensure safe and effective delivery of care and support is provided to residents.

Risk Managemet plan has been updated to clearly outline currentcontrol measures in place to mitigate against violence and agression.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
In order to meet compliance with Regulation 7: Positive Behavioural Support the following actions have been undertaken:

• A 15 minute monitoring chart was implemented on the day of inspection for one resident to ensure observation and recording of agreed protocols. Protocol's revised to capture practice 25-9-20.
• Residents representive/next of kin informed of all restrictions in place for their family member- 29-9-20.
• Person centred plan and Behaviour support plan, has been updated to clearly state the rationale and appropriate use of restrictive practice 25-9-20.
• Training has been completed in positive behaviour support by all required staff on the 06/10/2020.
Update 06/11/2020;
A compatability assessment has been completed for one resident at this centre. The outcome of this assessment is that one resident is not compatable with the other residents in Antoine House and it is unlikely that this resident will benefit in the long term from a community residential placement. With immediate effect Cavan Monaghan Disability Services will commence implementation of a bespoke support package providing this resident with her own house supported by two staff. To ensure the timeframes allow for the identification of an appropraite premises,a sufficient transition period and prepare both the resident and her family a time frame of 12 months is set to complete this process.
Additional staff has been provided for this service from 25/09/2020. Since there introduction the level of restrictions imposed on all residents has significantly reduced and in particular in relation to one resident.
In the interim period all restrictions will continue to be monitored on a weelky basis by the Director of Nursing, Person in Charge and relevant Multi Disciplinary Team.

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.	Not Compliant	Orange	24/09/2020
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	23/10/2020
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of	Not Compliant	Orange	06/11/2020

	purpose.			
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	06/11/2020
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the risks identified.	Substantially Compliant	Yellow	25/09/2020
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	25/09/2020
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	Substantially Compliant	Yellow	20/10/2020

	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.			
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.	Not Compliant	Orange	06/10/2020
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Orange	29/09/2020
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or	Not Compliant	Orange	25/09/2020

	environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			
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.	Not Compliant	Orange	07/11/2021
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	07/11/2021
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	07/11/2021