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:	Rivendell
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Carlow
Type of inspection:	Short Notice Announced
Date of inspection:	21 January 2021
Centre ID:	OSV-0007758
Fieldwork ID:	MON-0031667

About the designated centre

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

Rivendell provides 24-hour care for up to four Adult residents, both male and female from 18 years of age onwards. The designated centre provides care for adults whom require support with autism, intellectual disabilities, borderline personality disorder and or individuals who exhibit behaviours that challenge.The centre is a two storey building comprising of four individual self contained apartments located in a rural area of Co.Carlow. Amongst the local amenities are hairdressers, a library, local parks, a community centre, horse riding centre, GAA clubs, and a selection of restaurants and social groups. The staff team consists of social care workers and support workers. There is a full time person in charge of the centre, along with two team leaders and four deputy team leaders. The provider,Nua Healthcare, also provide the services of the Multidisciplinary Team. These services include; Psychiatrist, psychologist, Occupational Therapist, Speech and language Therapist and nurses.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Thursday 21 January 2021	10:00hrs to 16:30hrs	Sinead Whitely	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet with one resident on the day of inspection. Three residents had completed satisfaction questionnaires prior to the inspection, with support from staff. One resident declined meeting the inspector or filling out a questionnaire and this decision was respected. Key working sessions had been completed with the resident regarding the inspection prior to the inspectors arrival. Overall, the inspector found that while some residents reported satisfaction with the service, others reported they were not happy living there.

Measures were in place for the management of COIVD-19 in the centre on the day of inspection. Interactions between the inspector, and staff and residents were kept to maximum of fifteen minutes. Social distancing was maintained and face mask were worn in line with national guidance for residential care facilities.

The centre was a two story building with four self contained apartments. Each resident lived separately in these and did not meet in communal areas of the centre due to identified risks. Residents presented with complex behaviours and the environment was highly restrictive. This was secondary to their assessed needs, diagnosis and associated risks. While residents never met in person, a high level of peer to peer verbal incidents of abuse took place in the centre with residents shouting abusive language at each other through the centre walls. The inspector observed that the centre was loud at times during the inspection day, with shouting and banging heard on numerous occasions. Residents choice and control was impacted at times secondary to living with peer residents. Residents could not access communal areas of the house, including the kitchen, at all times secondary to risks associated with meeting peers and individual potential risks.

Following a review of completed questionnaires and a conversation with a resident, it was communicated that not all residents were happy living in the centre. Some issues reported included lights were left on all night, lack of privacy at times,and a lack of consistency with staffing changing regularly. Following conversations with staff and management, and a review of documentation, it was evidenced that some of these issues regarding privacy and family contact were due to identified risks. It had recently been identified that the centre and the setting was not suitable for one resident. Other residential options were being explored with the multi-disciplinary staff team supporting them. Some questionnaires also expressed high levels of satisfaction in areas including staffing, food, activities, and residents rights.

It was also communicated that a resident felt bullied by their peers living in the centre. Furthermore, while a resident reported that they really liked the staff, they also communicated that they don't like living in the centre and found the high levels of staff support annoying. When asked if they had made a complaint about this they communicated that they had but that the bullying, noise and shouting from peers seemed to still continue and nothing changed. The resident communicated that they regularly could not sleep with the noise. Following a review of documentation and

conversations with management, it was clear that extensive work had been done with this resident to attempt to address this complaint. However the resident continued to not be satisfied with the outcome.

The inspector observed that residents had a range of hobbies and activities that were supported by staff, despite COVID-19 impacting some residents daily schedules. The residents all had access to their own self contained gardens through their apartments. One resident had a trampoline in their garden and appeared to enjoy using this. Some residents enjoyed online activities on their technology devices. Other hobbies and activities included dancing, music, singing, artwork, sports, and going for drives. Some residents had recently enjoyed partaking in an online talent competition which had been facilitated by the provider. All residents had access to their own individual service vehicle.

The centre had high levels of staffing, with all resident supported by two staff members at all times. There was also a very regular management presence noted in the centre with a full time person in charge who was supported by two team leaders and four deputy team leaders. Staff spoken with, appeared knowledgeable regarding the residents individual needs and safeguarding measures in place. The inspector noted that the centre was spacious, well maintained internally and externally, and visibly clean and warm throughout the inspection day.

This was the centres first inspection and the purpose of this inspection was to monitor the centres levels of compliance with the regulations. In general, the inspector found that while there were strong management and staffing systems in place, issues including peer to peer verbal incidents and the inappropriate placement of one resident was impacting the centres levels of compliance in areas including residents rights, complaints, governance and management, protection and assessment and personal plans.

Capacity and capability

There was a clear management structure and lines of accountability in the centre. There was a full time person in charge in place who had the skills, experience and qualifications necessary to manage the designated centre. The person in charge was supported by two team leaders and four deputy team leaders. A regional director of operations, who was senior to the centres staff team, also supported the person in charge when required and attended the centre weekly. There was regular audits and reviews of the service provided with clear actions identified and persons responsible. A weekly report was submitted to senior management which identified any adverse incidents which had occurred in the centre. This was reviewed and actions identified when necessary. This report was also used to trend the occurrence of adverse incidents.

There were high levels of staff support in place in the centre, with all residents supported by two staff at all times. One to one staff supervision were being

completed every six weeks by staff line managers. A staff rota was maintained which clearly identified all staff on duty, day and night and daily allocation of staff and tasks were made clear. There was an internal relief panel of staff available to the centre to cover times of staff holidays of sickness.

Training was provided in areas in including fire safety, safeguarding, medication management, hand hygiene, behaviour management and manual handling. All staff had received up-to-date mandatory training on the day of inspection. Training needs were regularly reviewed and refresher training scheduled if required.

Residents records, including those specified in Schedule 3 and Schedule 4, were all well maintained and readily available. The inspector had outlined a number of documents to have to hand prior to the inspection day and these were all available and clearly laid out. Documentation requests made on the day of inspection by the inspector were addressed promptly by the person in charge and regional director of operations.

The person in charge had ensured that all adverse incidents and accidents in the designated centre, required to be notified to the Chief inspector had been notified. This included all uses of restrictive practices which had been notified on a quarterly basis.

The complaints procedure was clear and accessible to residents and was explained to residents on a monthly basis through key working sessions. However, two residents communicated that they were not happy living in the centre. One resident, was not happy with the management of their complaints and communicated that the bullying, noise and shouting seemed to still continue and nothing changed despite making complaints. Residents were supported to access advocacy services when required.

Regulation 14: Persons in charge

There was a full time person in charge in place who had the skills, experience and qualifications necessary to mange the designated centre.

Judgment: Compliant

Regulation 15: Staffing

There were high levels of staff support in place in the centre, with all residents supported by two staff at all times. One to one staff supervision were being completed every six weeks by line managers.

Judgment: Compliant

Regulation 16: Training and staff development

Training was provided in areas in including fire safety, medication management, hand hygiene, behaviour management and manual handling. All staff had received up-to-date mandatory training on the day of inspection.

Judgment: Compliant

Regulation 21: Records

Residents records, as specified in Schedule 3, were all well maintained and readily available. Documentation requests made on the day of inspection by the inspector were addressed promptly addressed by the person in charge and regional director of operations.

Judgment: Compliant

Regulation 23: Governance and management

There was a clear management structure in place and lines of accountability. It was evidenced that there was regular oversight and monitoring of the care and support provided in the designated centre and there was a very regular management presence.

However, there were high levels of peer to peer verbal abuse occurring in the centre meaning residents did not always live in a safe environment. Furthermore, it had been identified that the centre was not suitable to meet the needs of one resident living there. This had been recognised by the provider and multi-disciplinary team and other residential options were being explored.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge had ensured that all adverse incidents and accidents in the designated centre, required to be notified to the Chief inspector had been submitted

within the required time frames.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure was clear and accessible to residents and was explained to residents on a monthly basis through key working sessions.

One resident, was not happy with the management of their complaints and communicated that the bullying, noise and shouting seemed to still continue and nothing changed despite making complaints. Following a review of documentation and conversations with management, it was clear that extensive work had been done with this resident to attempt to address this complaint. However the resident continued to not be satisfied with the outcome.

Judgment: Not compliant

Quality and safety

All residents had a comprehensive assessment of need and personal plan in place. Monthly outcomes were identified with each resident residing in the centre, based on their individual goals. Monthly outcomes were discussed at team meetings in the centre on a monthly basis and were reflective of goals identified through the residents individual personal plans.

It had been identified that the designated centre was not suitable to meet the assessed needs of one resident living there. The inspector acknowledges that this had been recently identified prior to the inspection due to a change in the resident diagnosis and other residential options were being explored with the resident and the multi-disciplinary staff team supporting them.

The centre had appropriate fire management systems in place. This included containment systems, fire detection systems, emergency lighting, and fire fighting equipment. These were all subject to regular checks and servicing with a fire specialist. All residents had individual emergency evacuation plans in place and fire drills were being completed by staff and residents regularly, which simulated both day and night time conditions. These were being completed in a timely and efficient manner.

The registered provider had ensured that systems were in place for the assessment, management and ongoing review of actual and potential risks in the designated centre. All residents presented with potential high risks secondary to their diagnosis

and high staffing levels were in place to mitigate this risk. All residents had individual risk management plans in place and there was a centre risk register that identified all actual and potential risks. This was subject to regular review. Risks were a standing item on the agenda of all staff meetings and staff spoken with appeared familiar with risks associated with working with residents.

Measures were in place for protection against infection and the management of COVID-19 in the designated centre. A temporary shed was in place outside of the centre which was used for hand hygiene and the donning and doffing of personal protective equipment (PPE). The centre was visibly clean and the centre had implemented enhanced cleaning schedules. Easy read guides and social stories had been devised for residents regarding COVID-19, hand hygiene and cough etiquette. Staff were completing daily risk assessment questionnaires prior to coming on duty and staff and residents were completing regular temperature checks. Up-to-date national guidance was readily available to staff and staff were observed wearing PPE in line with national guidance for residential care facilities throughout the inspection day. All staff had received up-to-date training in infection control and the donning and doffing of PPE.

Residents presented with complex behaviours and lived in a highly restrictive environment. This was secondary to their assessed needs, diagnosis and associated risks. Residents had access to a range of multi-disciplinary supports to help them manage their behaviours including psychology, psychiatry and behavioural therapy. All residents had comprehensive behavioural support plans in place and clear rationale was evidenced for the use of restrictive practices. Any restrictive practices in place were subject to monthly reviews with a behavioural therapist. Reward systems were in place for some residents as a therapeutic intervention. One resident communicated in their questionnaire that they did not like having a bright light on all night in their bedroom. While this was implemented due to an identified risk, it was not evidenced that less restrictive measures had been considered or trialled, like a dimmer light.

All staff had received up-to-date training in the safeguarding and protection of vulnerable adults. Staff spoken with appeared familiar with reporting systems in place, should a safeguarding concern arise. However, residents were not safeguarded from verbal abuse at all times. While residents never met in person, a high level of peer to peer verbal incidents took place with residents shouting abusive language at each other through the centre walls. Measures were not in place on the day of inspection to eliminate the risk of this happening again. The registered provider had implemented some sound proofing systems to reduce the risk of residents shouting through the walls, however these appeared to be ineffective at times.

Regulation 17: Premises

The premises was well maintained internally and externally on the day of inspection.

The registered provider had ensured the provision of all matters set out in Schedule 6.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had ensured that systems were in place for the assessment, management and ongoing review of actual and potential risks in the designated centre. All residents had individual risk management plans in place.

Judgment: Compliant

Regulation 27: Protection against infection

Appropriate measures were in place for protection against infection and the management of COVID-19 in the designated centre.

All staff had received up-to-date training in infection prevention and control and the donning and doffing of PPE.

Judgment: Compliant

Regulation 28: Fire precautions

The centre had appropriate fire management systems in place. This included containment systems, fire detection systems, emergency lighting, and fire fighting equipment. These were all subject to regular checks and servicing with a fire specialist.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

All residents had a comprehensive assessment of need and personal plan in place which was subject to regular review.

The designated centre was not suitable to meet the needs of one resident living

there. The inspector acknowledges that this had been recently identified and other residential options were being explored with the residents multi-disciplinary team.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Resident were supported by a range of multi-disciplinary healthcare professionals to support them to manage their behaviours.

However, one resident communicated that they did not like having a bright light on all night in their bedroom. While this was implemented due to an identified risk, it was not evidenced that less restrictive measures had been considered or trialled, like a dimmer light.

Judgment: Substantially compliant

Regulation 8: Protection

Residents were not safeguarded from verbal abuse at all times when living in the centre. While residents never met in person, a high level of peer to peer verbal incidents took place with residents shouting abusive language at each other through the centre walls. The provider had implemented some sound-proofing systems in an effort to address this issue, however measures were not in place on the day of inspection to eliminate the risk of this happening again.

Judgment: Not compliant

Regulation 9: Residents' rights

Weekly Service User forum meetings were held where residents were given the opportunity to discuss any concerns they may have had.

Residents choice and control was impacted secondary to living with peer residents. Two residents reported noise levels affected their sleep. The provider had implemented some sound-proofing systems in an effort to address this issue. Residents could not access communal areas of the house, including the kitchen, at all times secondary to risks associated with meeting peers.

Judgment: Not 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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Rivendell OSV-0007758

Inspection ID: MON-0031667

Date of inspection: 21/01/2021

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. The Person in Charge, in conjunction with the Designated Centre's Behavioural Specialist, will conduct a full review of all Service Users Support Plans and strategies to ensure all supports in place are appropriate to their assessed needs and identified risks. 2. A full review of the Designated Centre's Centre Specific Safeguarding Plan is to be completed by the Person in Charge with the Designated Officer, to ensure all additional control measures are in place and strategies are clearly outlined to support Service Users. 3. All updated Support Plans and Safeguarding are to be briefed to the Designated Centre's Care Staff by the Person in Charge at their next team meeting on 25th April 2021 4. Where a Service User has been identified for discharge due to their change in needs, the Person in Charge will ensure that any discharge from the Designated Centre will be completed in line with our Policy and Procedure [PL-ADT-001] Admissions, Discharges and Transfers and in accordance with Regulation 25(3) to ensure the Service User receives all supports required prior to discharge.	
Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure:	

1. A Safeguarding Review meeting was held on the 18th December 2021 and on the 8th January 2021 by the Person in Charge where all safeguarding concerns and Service Users' complaint was reviewed and discussed. Additional controls and strategies were implemented in the Designated Centre.

2. A full review of the Designated Centre's Centre Specific Safeguarding Plan is to be completed by the Person in Charge with the Designated Officer, to ensure all additional control measures are in place and strategies are clearly outlined to support Service Users.

3. All updated Support Plans and Safeguarding are to be briefed to the Designated Centre's Care Staff by the Person in Charge at their next team meeting on 25th April 2021.

4. The Person in Charge will ensure that any measures required for improvement in response to a Service User complaint are put in place where appropriate to do so and the Service User has expressed their satisfaction with the outcome. If a Service User is not happy with the management of a complaint or the outcome of a complaint, the Service User can utilize the appeals process which is outlined in the Policy and Procedure on Comments, Compliments and Complaints [PL-OPS-002].

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
1. The person in charge to ensure that the Residents Comprehensive Needs Assessments (CNA) are updated at least annually and/or as required so as to ensure that the Designated Centre is suitable for the purposes of meeting the assessed needs of each resident.

2. Where a Service User has been identified for a transition or discharge due to their change in needs, the Person in Charge will ensure that any transition or discharge from the Designated Centre will be completed in line with our Policy and Procedure [PL-ADT-001] Admissions, Discharges and Transfers and in accordance with Regulation 25(3) to ensure the Service User receives all supports required from their Multi-Disciplinary team prior to a transition or a discharge.

Regulation 7: Positive behavioural	Substantially Compliant

support	

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
1. The Person in Charge to ensure that all Service User Personal Plans and Risk Assessments clearly document interventions which are deemed restrictive and outline the least restrictive procedure, for the shortest duration necessary, that is used.

2. All updated Plans are to be briefed to the Designated Centre's Care Staff by the Person in Charge at their next team meeting on 25th April 2021.

3. The Person in Charge will ensure that restrictive practices are reviewed in line with Policy and Procedure on Restrictive Practices [PL-C-005] and are recorded in a detailed manner whereby the rationale, justification for the restriction and exploration of alternatives are explored and trialed where identified and deemed safe to do so in line with the identified risk associated.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. A full review of the Designated Centre's Centre Specific Safeguarding Plan is to be completed by the Person in Charge with the Designated Officer, to ensure all additional control measures are in place and strategies are clearly outlined to support Service Users.

2. Designated Centre's Centre Specific Safeguarding Plan is to be briefed to the Care Staff by the Person in Charge at their next team meeting on 25th April 2021

3. The Person in Charge will conduct regular checks with all Staff through the Centre's 'On-the-floor management forms' to test their knowledge of the Safeguarding Plans and measures implemented.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The Person in Charge will ensure that all residents are consulted with and their choice and control are advocated for whilst residing in the Designated Centre in the following ways;

1. The Person in Charge will ensure that key working sessions are completed with the Service Users on a monthly basis to ascertain their views, choice and wishes in regards to their current living circumstances.

2. Where restrictive practices are implemented in the Designated Centre which necessitates from the Service Users identified risks, the Person in Charge will ensure that key working sessions are completed with the Service Users prior to their implementation so that the Service Users can participate and consent with supports where necessary.

3. The Person in Charge shall ensure that where Service Users daily lived experience in the Designated Centre are impacted on, that this is clearly recorded in Service Users Personal Plans and are Risk Assessed so as to ensure identified risks are mitigated to their lowest possible level and necessitates the Service Users views and wishes.

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 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.	Substantially Compliant	Yellow	31/05/2021
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Not Compliant	Orange	31/05/2021
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	Substantially Compliant	Yellow	31/05/2021

	paragraph (1).			
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.	Substantially Compliant	Yellow	31/05/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/05/2021
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	31/05/2021