Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Damara
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	05 November 2019
Centre ID:	OSV-0003446
Fieldwork ID:	MON-0027354

About the designated centre

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

Damara is a designated centre that provides residential support for both adults and children, male and female with intellectual disabilities. The centre is based on the outskirts of county Kilkenny on a campus style setting. The centre is one building divided into three separate bungalows, each with their own front door and it is located within walking distance of a busy city. The staff team consists of a team leader (person in charge), a nurse and healthcare assistants. The residents supported in Damara present with intellectual needs and may have a diagnosis of autism and other needs. The home is a seven day residence open all year with no closures. There are five people supported in Damara and the centre has the capacity for eight people. The centre, as confirmed in the statement of purpose is not open at present to new admissions. Two of the five residents live alone in their own bungalow. The remaining three residents, all within a similar age range, live in the third bungalow. The centre has three service vehicles available for use by residents.

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
05 November 2019	10:30hrs to 16:55hrs	Carol Maricle	Lead

What residents told us and what inspectors observed

On the day of the inspection there were three residents at home. The inspector was introduced to two residents and spent time with them and the staff team caring for them. The inspector was met a third resident briefly as they were going about their routine.

The inspector spent time with one resident engaging in discussion and chat with them about their chosen topics. The resident enjoyed showing the inspector their favourite items and telling the inspector about where they were going during the day. The staff caring for this resident presented as very knowledgeable of the resident and their needs. This resident was observed as taking pride in their appearance and was dressed and tailored in line with their age. They presented as comfortable, relaxed and content. They were observed leaving the centre with staff to do errands and visit a former resident of the centre.

A second resident was met with on their return from school and they presented as relaxed and content in the company of the staff caring for them. The staff described to the inspector how they knew how the resident was feeling as indicated by their body language and gestures. The resident, through their body language, indicated that they were comfortable and happy.

As the inspector met only briefly a third resident, time was spent with their care team. The staff team told the inspector that they believed the resident had a good life at the centre and enjoyed having their own space in what was now their own bungalow.

As the majority of the residents did not communicate verbally with the inspector about their experience of being cared for, their views were based on the observations of the inspector as they interacted with staff and their general presentation over the course of the inspection. All residents presented as comfortable in their surroundings, familiar with the staff team on the day and content in their receipt of care and attention from staff.

Capacity and capability

This centre had been identified for the purpose of completing a risk based inspection based on the findings of the previous inspection and the receipt of a provider assurance report received by the Health Information and Quality Authority (HIQA).

This centre is a registered centre with plans to decongregate in 2020. While the centre remained in a congregated setting the provider had made attempts to address the findings of the previous inspection and had made clear advances in improving aspects of the service, such as the internal condition of the premises.

Overall, since the previous inspection, the residents living at this centre now experienced an improved level of leadership, governance and management of their home and this resulted in their experience of a better standard of living. Notwithstanding these positive improvements, there were some areas identified throughout the inspection that were not in compliance with the Regulations and these are highlighted in this report.

During the course of this inspection, the inspector viewed evidence of enhanced leadership and governance by the person in charge and those involved in the wider management of the centre. In accordance with the Regulations the provider is required to carry out unannounced visits to the designated centre every six months to review the quality and safety of care and support that is provided to residents. Since the previous inspection, representatives of the provider had carried out a six monthly inspection and an annual review of the centre and this ensured that there was good oversight of the centre. The inspector reviewed both of these unannounced visits reports and found them to be detailed and in-depth while the action plans in place assigned responsibility for responding to the issues identified. The annual review provided for consultation with residents and their families which was mostly positive. The person in charge was cognisant of the action plan for both the six month inspection and the annual review and had systems in place to track the completion of actions required. At the time of this all actions had being progressed or had been closed off.

This service was a mixed service therefore it could provide services to both children and adults. The inspectors found that the age range of the residents at one of the bungalows was similar thus ensuring compatibility in their life stages. The person in charge and person involved in the management of the centre were knowledgeable of the changing needs of the residents as they entered adulthood.

Since the previous inspection, there had been a change in the person in charge post-holder and this new post-holder demonstrated leadership in their role. They worked full-time at this centre with their office based at one of the bungalows. They were suitably qualified and experienced. They were very knowledgeable of the relevant regulations and standards and they had good systems in place to ensure that the day-to-day running of the centre was in line with the needs of the residents. They showed the inspector evidence of the oversight arrangements put in place since their appointment. Despite these positive improvements the inspector identified a number of gaps in the oversight of day-to-day finance recording and oversight of the use of restrictive practices.

There were adequate resources in place to ensure service provision. The inspector viewed evidence of appropriate staffing arrangements to support residents. Residents had the use of vehicles to promote their day to day living and being out in the community. There was a multidisciplinary team available to all residents as part

of the suite of services offered by the provider. The residents had homes that were mostly in good condition, although in one of the bungalows vacant bedrooms were not well maintained. At the time of this inspection, a decongregation plan was in place for all residents of this centre and the management team had specific plans for all but one of the residents. Where a specific plan was not in place the inspector saw evidence of this issue being actively discussed and progressed at a wider management level.

Since the previous inspection, staff were now better trained and there was oversight of their training needs. Residents were supported by continuity of staff. Staff were supported in carrying out their role with opportunities for continuing professional development. Staff members spoken with by inspectors demonstrated a detailed knowledge of the needs of the residents and the supports they required. It was observed that staff members on duty interacted with residents in a positive and respectful manner during the inspection. Staff received training in relevant areas such as safeguarding, behaviour that challenged and fire safety. Since the previous inspection, a formal system of supervision had commenced within the centre.

The inspectors saw evidence that the provider used, collected and evaluated information and by doing so they responded to information thus striving to provide a quality service. There were systems in place at a provider level and at person in charge level for the oversight of aspects of the service. Notwithstanding these systems, some improvements were required in the oversight of restrictive practices and the personal finances of residents. The directory of residents had a small number of gaps. The person in charge showed evidence to the inspector of trending completed on areas such as accidents and incidents. The inspector could see evidence of management oversight of such incidents and also that these incidents were analysed by the multidisciplinary team and where necessary the wider management team (at regional manager level). Where there were open incidents of a safeguarding manner these were known by the management team and the designated officer and being dealt with in line with statutory processes.

Regulation 14: Persons in charge

The registered provider had appointed a suitable person in charge who had the requisite knowledge and experience relevant to the role.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had ensured that staff had the required training in child and adult safeguarding and managing behaviour that is considered challenging.

Judgment: Compliant

Regulation 31: Notification of incidents

Since the previous inspection, the person in charge had submitted the required notifications to the Authority.

Judgment: Compliant

Regulation 19: Directory of residents

There were a small number of gaps identified in the directory of residents.

Judgment: Substantially compliant

Regulation 23: Governance and management

Since the previous inspection, the registered provider had put in place systems to govern and manage the centre in a safe manner. There were some practices identified at this inspection that were not fully compliant with the Regulations and required better oversight by the management team.

Judgment: Substantially compliant

Quality and safety

The inspector reviewed the quality and safety of the service and practice in this area had significantly improved since the previous inspection. Some improvements were however identified to ensure that the provider was fully in compliance with the Regulations.

This inspection found that there was a focus on the needs of the residents and the supports available to them, as evidenced by the inspector reviewing documentation, engaging in conversation with staff and observing the care given by staff to the residents. Since the previous inspection, two residents now resided alone in their own bungalow and these arrangements were described by staff and the management team as having had a significantly positive impact on the quality of life for each resident.

In one of the bungalows the inspector interacted with two of the three residents in addition to staff caring for them. These residents were observed as being very comfortable, at ease and happy as they went about their day to day routines. The staff caring for them were very knowledgeable of their needs, their likes and dislikes. They were observed engaging in discussion and chat with a resident and there was lots of laughter in this home. There was music playing in the background in keeping with their age. They were aware of how both residents liked to communicate. It was found by the inspector from discussions and review of documentation that those involved in decisions about the future of all residents in relation to the plans for decongregation were very mindful of the strengths and needs of each resident. This was especially the case for any residents who had turned or were about to reach young adulthood.There was evidence that residents were supported to visit their families. The inspector spoke with staff and reviewed documentation that demonstrated staff supporting residents to visit families.

The inspector found that since the previous inspection arrangements had been put in place to ensure that residents were kept safe than previously was the case. There was better oversight of care and quality of service through more frequent day-to-day contact between the person in charge and the staff team. A formal system of supervision had also commenced. In keeping with the nature of the service, all staff were trained in both child and adult safeguarding. Where there had been concerns raised of a safeguarding manner the person in charge and wider management team had acted promptly and in line with statutory requirements. The inspector found records of open safeguarding plans in the files of some residents and the person in charge acknowledged that these required closing and filing.

The inspector was informed that that there had been two transitions since the previous inspection, the circumstances of which were discussed with the inspector by the regional manager. It was acknowledged by the regional manager that the transitions were carried out without significant time afforded to consult with the residents and family and that this was not in keeping with their transitions and

discharge policy.

The inspector found that there were some environmental restrictive practices in place. One of the bungalows used more restrictive practices than the others as bedrooms and bathrooms that were not in day to day use were locked. The kitchen door was also locked during meal preparation times. The bathroom used by a resident in this bungalow was also locked. These practices were described by the person in charge as having been approved by an internal committee within the organisation. The inspector found that the implementation of these restrictive practices was not in line with the provider's own organisational policy as the suite of tools that accompanied the policy were not in use. Furthermore, up-to-date sanctioning of the restrictive practices was not available on the day of the inspection. The use of a specialised bed, described by the person in charge and a regional manager as having been recommended by a healthcare professional was not fully evidenced through documentation.

On the day of the inspection, the inspector found that the recording systems in place for the day to day tracking of the personal finances of residents was not consistent across all three bungalows. The forms were not correctly completed, there was not always a double signature evident and there was a lack of oversight by the person in charge of the record keeping. While the inspector did not find evidence of financial mis-management the system of record-keeping was not robust.

During the walk around of the centre, the inspector viewed a sample of residents' bedrooms throughout all three bungalows and found them to be nicely decorated and personalised while facilities were available for residents to engage in recreational activities outdoors. The inspector found that some rooms that were not in use (vacant bedrooms) were not kept to a high standard of cleanliness. Although these rooms were not in use their condition was not in keeping with the rest of the house. Furthermore two bathrooms in one of the bungalows were of poor standard. These rooms were also not in use however this meant that the standard of cleanliness and the overall condition of some rooms in the home of a resident was not consistent. There was broken tiles in the kitchen which also lent itself to an unkempt appearance.

Regulations relating to fire were not inspected in full at this inspection, however, it was observed by the inspector during their walk around of the centre that a fire door in one of the bungalows did not have a door closure in place and this door was also held back with a wedge. An emergency break glass call point was covered with tape therefore this may prevent a person activating this in the event of a fire. These issues were observed being dealt with by the person in charge immediately during this inspection.

Regulation 8: Protection

Since the previous inspection, the person in charge demonstrated that actions arising from the previous inspection had been put in place. Staff were appropriately trained in child and adult safeguarding.

Judgment: Compliant

Regulation 28: Fire precautions

One fire door was observed by the inspector to be without a working door closure. This door was also held open with a wedge. An emergency break glass point was covered in tape thus preventing its use. The person in charge attended to these issues on the day of the inspection.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The use of restrictive practices was not in line with organisational policy.

Judgment: Substantially compliant

Regulation 12: Personal possessions

The records pertaining to the resident finance transactions had gaps and were not maintained in a consistent manner across all three bungalows.

Judgment: Substantially compliant

Regulation 17: Premises

In one of the bungalows, the condition of two bathrooms and two vacant bedrooms was not suitable. The condition of the kitchen in bungalow two although improved since the previous inspection had broken tiling.

Judgment: Substantially compliant

Regulation 25: Temporary absence, transition and discharge of residents
Where discharges had taken place since the previous inspection, the person involved in the management of the centre acknowledged that the transitions had not been fully carried out in line with the provider transition policy.
Judgment: Substantially 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 16: Training and staff development	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 8: Protection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 25: Temporary absence, transition and discharge of residents	Substantially compliant

Compliance Plan for Damara OSV-0003446

Inspection ID: MON-0027354

Date of inspection: 05/11/2019

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 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: The PIC and Quality Department have updated the Directory of Residents for Damara to include current pictures of all people supported and ensure all dates of admission and date of birth are correct. The updated Directory of Residents is now available in Damara in the house folder No. 1.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Quality Conversations: The PIC has a system in place to ensure all Quality Conversations are completed with the staff team in Damara. Quality Conversations are completed as per policy on a 6 weekly basis. Each Quality Conversation has a set agenda and SMART action plans, which are followed through. The CSM and PIC have scheduled Quality Conversations and also attend the monthly Team Leader meetings. Monthly PIC reports: The Quality Department and Community Service Managers within St. Patrick's Centre (Kilkenny) have developed a monthly report template which supports and ensures the management and governance between the CSM and PIC.	

The monthly report template is completed by the PIC on the last Friday of the month and is providing basis for the Quality Conversations between CSM and PIC.

Provider audits:
An annual provider audit was completed in August 2019. The next six monthly provider audit is scheduled and will be completed latest by 25/12/2019.

Identified actions from the audits are part of the PIC's action plans for completion and delegated duties to discuss at team meetings and Quality Conversations.

A schedule for completion of Provider audits has been developed by the Quality Department for 2019 and 2020. People responsible for completion were identified and timeframes set.

Restrictive Practices:
The PIC and staff team have reviewed the restrictive practices and risk assessments for all people supported in Damara since the inspection took place.
Risk assessments were updated to reflect current living arrangements for each person. Also new referrals to the Human Rights Committee were completed after the restrictive interventions were assessed and reviewed.
The PIC and staff team have decided at a team meeting on the 25/11/2019 to start a trial period of a restrictive intervention for one person supported to assess the need for the intervention, which commenced on the 02/12/2019. Learning from this trial period will be discussed and any changes implemented.

Finances:
The inspector identified that documentation of finance checks were not consistent within the 3 houses in Damara, also sometimes signatures of the PIC or staff member was missing.
The PIC held Team Meetings in Damara to discuss the Finance Pathway with the staff team and ensure correct completion of documentation.
The PIC has scheduled every Monday morning to sign off on financial transactions and documentation to provide a better oversight.

Due to feedback given by the Inspector on the day of the visit in Damara, the PIC developed a new template for the daily expenditure sheet to simplify the currently used template in SPC. This draft template was submitted to the Finance Department for approval on the 26/11/2019. The new expenditure sheet will be rolled out from the 04/12/2019 for all designated centres in SPC.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
On the day of the inspection the PIC removed the wedge from the fire door immediately.

The PIC requested the repair of the fire door (door closure), which was completed on the 06/11/19.
On the same day the PIC ordered a hold open device for the same fire door, which has not been delivered yet.

All the black tape has been removed from any emergency break glass points, with no adverse effects for the person supported. Also all break glass points were cleaned to ensure clear visibility of same.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The PIC and staff team have reviewed the restrictive practices and risk assessments for all people supported in Damara since the inspection took place.
Risk assessments were updated to reflect current living arrangements for each person. Also new referrals to the Human Rights Committee were completed after the restrictive interventions were assessed and reviewed.
The PIC and staff team have decided at a team meeting on the 25/11/2019 to start a trial period of a restrictive intervention for one person supported to assess the need for the intervention, which commenced on the 02/12/2019. Learning from this trial period will be discussed and any changes implemented.

Regarding one person supported's bed the PIC has followed through on actions discussed with the inspector on the day of inspection.
The Occupational Therapist was contacted immediately after the inspection to review the bed for the person supported. A new bed was approved and sourced. The fitting of a new mattress is currently in process. The PIC is expecting the delivery of the new bed and mattress for the person supported in January 2020.

The SPC restrictive practice policy is currently under review. The SPC working group met on the 15/10/2019 to develop a new Restrictive Intervention Policy and Flow Chart to guide employees.

Due to the financial situation in SPC the planned Quality Training Session around Restrictive Interventions on the 20/11/2019 had to be re-scheduled for January 2020.
The PIC and delegated staff member will be attending the next training session to build capacity around restrictive interventions.
The HIQA assessment tool will be used in preparation for this training to reflect on current practices being used and developing new ideas.

All staff in Damara will have completed Studio 3 training in January 2020. One staff

member is also a Studio 3 trainer and working as a nurse in Damara.

Positive behaviour support sessions are part of the monthly team meeting agenda in one house in Damara to build capacity within the staff team.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
The inspector identified that documentation of finance checks were not consistent within the 3 houses in Damara, also sometimes signatures of the PIC or staff member was missing.
The PIC held Team Meetings in Damara to discuss the Finance Pathway with the staff team and ensure correct completion of documentation.
The PIC has scheduled every Monday morning to sign off on financial transactions and documentation to provide a better oversight.

Due to feedback given by the Inspector on the day of the visit in Damara, the PIC developed a new template for the daily expenditure sheet to simplify the currently used template in SPC. This draft template was submitted to the Finance Department for approval on the 26/11/2019. The PIC is awaiting feedback.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The PIC requested a deep clean of two bathrooms and two vacant bedrooms, which was completed on the 07/11/2019.

Due to SPC being in the process of de-congregating, priority has been given to more pressing repairs. Therefore the 2 broken tiles in the kitchen are not top priority to be replaced at this time.
The person supported living in this house is planned for transition to their new community home in April 2020.

Regulation 25: Temporary absence, transition and discharge of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence, transition and discharge of residents:
SPC is committed to adhere to the transition policy and good transition planning for all people supported.

Due to St. Patrick's Centre (Kilkenny) currently being in the process of de-congregation two people supported had experienced internal moves in 2019 due to safeguarding issues in Damara.
Because transition to their future homes was not possible as planned at that stage both people transition within SPC to campus houses. Both people supported are experiencing a better quality of life since their moves.

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Substantially Compliant	Yellow	26/11/2019
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	10/11/2019
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	29/11/2019

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	25/12/2019
Regulation 25(4)(b)	The person in charge shall ensure that the discharge of a resident from the designated centre take place in a planned and safe manner.	Substantially Compliant	Yellow	25/12/2019
Regulation 25(4)(d)	The person in charge shall ensure that the discharge of a resident from the designated centre is discussed, planned for and agreed with the resident and, where appropriate, with the resident's representative.	Substantially Compliant	Yellow	25/12/2019
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	15/12/2019
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for	Substantially Compliant	Yellow	15/12/2019

	reviewing fire precautions.			
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	25/01/2020
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.	Substantially Compliant	Yellow	20/12/2019
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Substantially Compliant	Yellow	20/12/2019
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates	Substantially Compliant	Yellow	20/12/2019

	intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.			
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	20/12/2019