Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	Mountain View Residential & Respite Services
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	03 April 2019
Centre ID:	OSV-0003702
Fieldwork ID:	MON-0026281

About the designated centre

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

Mountain View Respite and Residential Services comprises of two houses in two neighbouring housing developments in Co Mayo. One house is a four bedroom bungalow and the second house is a two-storey, seven bedroom house. The centre is registered to provide residential and respite services for up to eight people. The centre provides services for male and female residents with an age range of 25–67 years. Residents require varying levels of support ranging from high support to those who have low support needs. One house provides a residential service for one full-time resident and two respite users and the second house provides respite service for up to 20 residents on a rotational basis, based on their assessed needs.

The following information outlines some additional data on this centre.

Current registration end date:	18/06/2020
Number of residents on the date of inspection:	3

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
03 April 2019	09:00hrs to 17:00hrs	Thelma O'Neill	Lead
03 April 2019	09:00hrs to 17:00hrs	Ivan Cormican	Support

Views of people who use the service

On the day of the inspection, inspectors met one resident who was receiving an individualised respite service.This was a new arrangement since the last inspection. The resident chose not to communicate verbally with the inspectors, but he came and sat with inspectors while having his breakfast. The resident was very relaxed and was supported by two staff. Staff told the inspectors that the new respite admission arrangement was a very positive experience for the resident as he was receiving individualised respite which was more suitable for meeting his needs. A group of three residents were due to come into respite in the evening; however, inspectors did not meet these residents during the inspection.

Capacity and capability

The centre's governance structure was enhanced since the last inspection, and there were now clear lines of authority and responsibility in the centre. In addition, the inspector found that the provider had ensured that residents received individualised and person centred care. However, improvements remained to be addressed in the management of risks, protection and oversight of the centre.

The last inspection found eleven of the fourteen regulations were non-compliance. A warning letter was issued to the provider and the provider was required to bring this centre back into regulatory compliance.

This inspection was conducted to follow-up on the non-compliance's identified on the last inspection and inspectors found four of the fourteen regulations inspected remained not-compliant, four were substantially compliant and the remaining regulations were fully compliant. The findings show that the provider is making progress in bringing the centre back into regulatory compliance, however further improvements were required.

The provider completed an annual review and the six monthly unannounced audits in 2018 to review the quality and safety of care delivered in the designated centre. The reviews had identified some areas that required action and these were being implemented at the time of the inspection.

Staff told inspectors that the person in charge had an active presence in the centre and was very supportive to them in her role. Regular discussions were held with the residents to discuss issues, such as, activity planning, food and nutrition, general duties and care and support issues. Inspectors were told that each resident had a key worker who maintained residents documentation; however, inspector reviewed

residents files and found that more oversight by the person in charge was required, as there were gaps in residents' notes and individual risks were not appropriately managed.

Inspectors found there were a number of adverse events that were not notified to the Health Information and Quality Authority as required in regulation 31. These included, safeguarding concerns, and accidents and incidents.

On the day of inspection, inspectors found that the numbers of staff present supported the residents to live a good quality of life and a review of the rota indicated that residents received consistency of care from staff members who were familiar to them. Team meetings occurred on a regular basis which facilitated staff to raise any concerns they had about the safety and quality of care in the service.

There was a schedule of mandatory and refresher training in place and records indicated that the majority of staff had met their minimum training requirements; however, one staff member was not up-to-date in supporting residents with behaviours of concern. Additional training in fire safety, epilepsy and safeguarding had also been identified as a need since the last inspection of this centre and bespoke training in these areas had been offered prior to this inspection; however, not all staff members had attended the additional safeguarding training and issues were found on this inspection in regards to the identification and reporting of safeguarding concerns.

Regulation 15: Staffing

Staff who met with inspectors had a good knowledge of residents' individual care needs. The person in charge maintained an accurate rota which indicated that residents received continuity of care from staff members who were familiar to them.

Judgment: Compliant

Regulation 16: Training and staff development

There were comprehensive training records in place and a review of these records indicated that the majority of staff members had met their minimum training requirements, but one staff member had not completed refresher training in supporting residents with behaviours of concern.

In response to the findings of the previous inspection, additional training was facilitated in regards to epilepsy, fire safety and safeguarding; however, not all staff members attended the additional safeguarding training and issues in regards to

the identification and reporting of safeguarding concerns were noted on this inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

Since the last inspection, the provider had improved the quality and safety of care provided to residents. However, not all of the non compliances identified on the previous inspection and in the warning letter issued to the provider had been addressed.

The provider failed to ensure the management arrangements were effective in sustaining the quality and safety of care provided in the centre. For example, improvements were required in the oversight of documentation, health and safety and risk management, protection, fire safety, timely access to allied health professionals, staff training and development.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had produced a statement of purpose which clearly outlined the supports provided to meet residents' assessed needs.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge failed to notify the chief inspector in writing of adverse advents which occurred at the designated centre in accordance with the regulations.

Judgment: Not compliant

Quality and safety

Improvements were found in the quality and safety of care provided to residents in

areas such as; premises, medication management, healthcare, and residents rights. However, inspectors found residents were at risk in the centre, due to safeguarding risks not being effectively managed.

Staff told inspectors that there was a good improvement in the support available to them as a staff team in the delivery of care, in relation to; the premise, equipment, staff training, and support from allied health professionals. They also said that they had received training in health and safety and had met several allied health professionals to review residents healthcare needs.

The provider had completed a review of medication management practices and medication errors in this centre and had put a quality improvement plan in place. The reviewed plan ensured regular stock control of medication, and that safe administration of medication practices were in place and in-line with the organisation's policy and procedures. There was also a marked decrease in the number of recorded medication errors since the last inspection as a result of the actions implemented by the management and staff team.

The provider had fire safety precautions in place in the centre. Fire safety equipment such as fire doors, alarm panel, fire extinguishers and smoke detection devices were in place, and the provider had ensured that a schedule of external servicing was in place. Staff members were conducting regular reviews of this equipment to ensure that it was in good working order. However, the provider had not addressed the findings from the last inspection and further actions were required, as available records indicated that not all residents had been involved in a fire drill. Furthermore, a fire drill had not been completed to ensure that residents could be evacuated when minimum staffing arrangements were in place at the centre. Some improvements were also required to documentation as resident's individual evacuation plans had not been reviewed since 2017 and did not include all supports to meet their assessed needs such as access to rescue medication in the event of an evacuation from the centre.

Some care practices in the centre were implemented in response to the health care needs of a resident. The resident had a clear plan of care in place and they were reviewed on a regular basis by relevant healthcare professionals. These reviews recommended that a specific night-time staffing arrangement should be available; however, inspectors found the implemented arrangements were not aligned to these recommendations and could be considered a restrictive practice. Inspectors found the provider had not identified this practice as restrictive and this lack of oversight meant that these care arrangements had not been reviewed to examine alternative measures or to ensure that this practice was implemented with the informed consent of relevant stakeholders. This was brought to the attention of the provider on the day of inspection and there was evidence that relevant staff members were requesting a review with relevant healthcare professionals to gain further clarity on the recommended night-time staffing arrangements.

Inspectors found that there was guidance in place to support some residents who required support with behaviours of concern. This guidance was found to be comprehensive in nature and assisted in ensuring that a consistent approach was

provided in this area of care. However, two residents who presented with complex behaviours of concern did not have behaviour support plans, and a referral had been sent to the allied health professional for review.

Risk management practices and procedures were reviewed by the provider since the last inspection and the risk register was updated to reflective of the risks as well as all of the residents' individual risk. However, all risks were not updated in line with the risk management policy and procedures accordance with the requirements of Regulation 26.

The provider had reviewed the compatibility issues of residents receiving respite together to ensure that all respite admissions were compatible. However, the actions taken to-date was not sufficient to ensure all residents were adequately protected. Inspectors were told that some residents had requested not to attend or clearly refused to attend respite with some of their peers; however, despite their concerns, their wishes were not always respected and residents had attend respite together despite their concerns. Furthermore, these concerns were not documented in the residents' files and the individuals of concern did not have safeguarding plans or behaviour support plans in place to minimise the risks to their peers.

Inspectors also found from speaking to the staff and the manager about how they responded to safeguarding concerns, that their practice did not adhere to the organisational safeguarding policy and procedures. Staff were provided additional safeguarding training since the last inspection, however, many staff did not attend this training. Furthermore, the person in charge had not reported all safeguarding concerns to the Chief Inspector as required; for example, peer to peer incidents and occasions of unexplained bruising.

Furthermore, inspectors found documentation was not updated in-line with residents' needs, for example; fall management , healthcare assessments and allied health reviews were not recorded in some of the sampled residents' files, with in some cases no plan of care being in place to outline how acute or chronic health conditions were to be supported by staff.

Regulation 17: Premises

The outstanding maintenance works identified on the previous inspection were all complete and the provider had implemented an effective system to manage ongoing maintenance issues in the centre.

There provider was also reviewing the suitability of the respite house to meet the residents' care and support needs.

Judgment: Compliant

Regulation 26: Risk management procedures

The inspectors found that management of risks in the centre required improvement. The provider had systems in place to identify risks in the centre; however, additional supports were required to ensure that risks were effectively managed. In addition; the inspectors also found some individual risks were not updated appropriately on their risk assessment, and in some cases there were not adequate support plans in place to manage these risks.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had installed fire safety equipment which promoted the safety of residents; however, fire drills had not been completed under all circumstances to ensure their effectiveness such as minimum staffing arrangements and not all residents had taken part in a fire drill. Furthermore,resident's individual evacuation plans had not been reviewed since 2017 and some of these plans failed to outlined all supports required to meet residents' assessed needs in the event of an evacuation.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Resident's independence was promoted as assessments had been completed to support them to manage their own medications. There was also a marked decrease in the number of recorded medication errors since the last inspection as a result of actions which were implemented by the management and staff teams.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The provider was supporting residents to achieve their healthcare needs. However, there was an absence in the files viewed of an annual assessment of the residents' health and social care goals. In addition, although some residents had received multi-disciplinary reviews, these were not accurately recorded in the residents'

personal plans.

Judgment: Substantially compliant

Regulation 6: Health care

Residents generally received their primary healthcare support from home; however, some residents required additional care or support while in respite, and had received allied health professional assessments to meet their assessed needs since the last inspection, or were due to be reviewed shortly.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were comprehensive support plans in place which promoted consistency of care for residents who may engage in behaviours of concern and recent referrals had also been made for some residents for further behavioural support. However, some improvements were required in regards to the implementation and oversight of restrictive practices to ensure that consent was gained prior to their use and the least restrictive practice was adopted.

Judgment: Substantially compliant

Regulation 8: Protection

Inspectors found that all resident attending respite services were not adequately protected in this centre. Residents at risk did not have safeguarding plans in place and staff were not familiar with the organisational safeguarding policy.

Judgment: Not compliant

Regulation 9: Residents' rights

The actions from the last inspection had been implemented with additional works completed to the premises which promoted the privacy and dignity of residents. The

provider was also in the process of reviewing care practices which were impacting on the rights of some residents. Rights assessments had been completed which had identified issues and additional reviews with relevant medical professionals were requested in order to examine the possibility of alternative care arrangements.
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
Views of people who use the service	
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Mountain View Residential & Respite Services OSV-0003702

Inspection ID: MON-0026281

Date of inspection: 03/04/2019

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The provider will arrange for an additional bespoke safeguarding training event for all staff who were unable to attend the previous training event on 28/01/2019. This will be completed by 17/05/2019. The staff member who requires training on Behaviours of Concern will attend training by 7/06/19. In the interim a bespoke training event for the person has been arranged for completion by 29/05/19	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Staff, manager and senior service managers involved will continue to work to review and monitor all risk and documentation within the service including individual risks, compatibility risks, premises and staffing risks, and will work to develop systems for improved overall governance of risk. A governance framework has been developed to structure meetings within this service so that all issues of concern are followed up and that the effectiveness of this follow up is monitored and tracked. Specific service review meetings will be held to monitor progress on issues raised attended by staff, line managers and relevant personnel. This first meeting is scheduled for 10/05/2019	

The committee will then continue to provide oversight and support, through the line management structure, on the management and governance of risk within the centre.

The provider has conducted an unannounced inspection on 17/04/19 and an action plan has been developed and agreed with the person in charge. A further unannounced inspection will take place by 30/06/19 to monitor and assess progress.

The Head of Residential and Respite Services and the PPIM will attend monthly meetings to review progress on action plans within the service and provide additional organizational supports as required

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The Person in Charge submitted outstanding notifications to HIQA on 17/04/19 and has received further guidance on regulatory requirements regarding notifiable events.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The Staff, manager and senior service managers involved will continue to work to review and monitor all risk and documentation within the service including individual risks, compatibility risks, premises and staffing risks, and will work to develop systems for improved overall governance of risk. A governance framework has been developed to structure meetings within this service so that all issues of concern are followed up and that the effectiveness of this follow up is monitored and tracked. Specific service review meetings will be held to monitor progress on issues raised attended by staff, line managers and relevant personnel. This first meeting is scheduled for 10/05/2019

The committee will then continue to provide oversight and support, through the line management structure, on the management and governance of risk within the centre.

The person in charge will review all individual evacuation plans to ensure that all relevant personal information is contained within the plan, including emergency medication. This will be completed by 30/05/19

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A fire drill took place on 07/04/19 involving minimum staffing levels at a time when there was a maximum number of service users present in the centre.

The person in charge will develop a schedule to plan and implement fire drills to ensure residents and staff will complete the required number of drills per year as per regulations. This will be implemented by 10/05/19

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:
The provider will complete an audit of all individual assessments and personal plans to ensure that all assessments on health and social goals are captured. This will be completed by 31/05/19

The person in charge will ensure that all records on multi-disciplinary reviews are accurately recorded in the resident's personal plans. This work will be complete by 31/05/19

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The provider will review all restrictive practice to ensure that least restrictive practice is adopted and consent is gained in line with good practice and this will done in consultation with the relevant health professional.

All epilepsy management plans and information on the rationale for the use of

observation as a restrictive practice for the individual with serious epilepsy has been reviewed following a bespoke epilepsy training event and input from the organisations' best possible health lead 06/05/2019

Final sign off of the required observation protocol for this person will be undertaken in consultation with the neurologist involved. However, this is dependent on securing an urgent review appointment with neurology. At present, the soonest available appointment is 17/07/2019

Following the appointment, if the observations safeguards remain in place, these will be set out specifically in the individual's epilepsy plan and specific consent for this will be sought from the individual's family.

In future, any use of observation will be closely monitored as restrictive practice, reported to HIQA as such and kept under active review.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The provider will arrange for an additional bespoke safeguarding training event for all staff who were unable to attend the previous training event on 28/01/2019.
This will be completed by 17.05.19. This training will clarify organizational policy and regulatory requirements regarding the notification and management of safeguarding concerns.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	07/06/2019
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.	Not Compliant	Orange	30/06/2019
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall	Not Compliant	Orange	17/04/2019

	carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	30/06/2019
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to	Substantially Compliant	Yellow	10/05/2019

	ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.			
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.	Not Compliant	Orange	17/05/2019
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.	Substantially Compliant	Yellow	30/05/2019
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety	Substantially Compliant	Yellow	10/05/2019

	management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	17/04/2019
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Yellow	17/04/2019
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive	Substantially Compliant	Yellow	31/05/2019

	assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/05/2019
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.	Substantially Compliant	Yellow	06/05/2019
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all	Substantially Compliant	Yellow	17/07/2019

	alternative measures are considered before a restrictive procedure is used.			
Regulation 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.	Not Compliant	Orange	17/05/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	17/05/2019