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:	MooreHaven Centre
Name of provider:	MooreHaven Centre (Tipperary) Designated Activity Company
Address of centre:	Tipperary
Type of inspection:	Unannounced
Date of inspection:	02 April 2019
Centre ID:	OSV-0003723
Fieldwork ID:	MON-0023933

About the designated centre

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

MooreHaven is a designated centre located in Co. Tipperary which provides residential care for adults over the age of 18 years. The centre provides supports to 18 full-time residents both male and female with an intellectual disability and autism. Respite support can be afforded to one service user at the one time. The centre is comprised of four dwellings in close proximity to local amenities and facilities within a town center. The service operates on a 24 hour, seven days a week basis with staff present within the centre to support residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	18

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
02 April 2019	09:30hrs to 16:30hrs	Laura O'Sullivan	Lead

Views of people who use the service

The inspector had an opportunity to interact with a number of residents through the day of the inspection. All residents were attending a day service and were afforded the opportunity to speak with the inspector if they wished to. Four residents asked to do so. All individuals spoke highly of the service and of the supports afforded to them. All spoke of being happy in their home and how they got along with their peers.

One individual spoke of activities that they liked to enjoy and stated that their staff would always be with them going out and about. They enjoyed bowling and swimming. Another person spoke of their goals for the coming year. They told the inspector that staff would help them to achieve these goals such as learning to use the washing machine. Residents spoke of the residents meetings that were held in the house and that they sat and decided on their meal plan for the week and what they wanted to do at the weekend if they were not going home to family.

Staff members spoken with had a clear knowledge and understanding to the needs of the residents and spoke respectfully of residents at all times interactions observed were positive in nature with a jovial atmosphere evident in conversations.

Capacity and capability

The inspector reviewed the capacity and capability of the centre and found improvements had been made in the service provided since the previous inspection. Through a clear governance structure and effective monitoring systems measures were implemented to address a number of identified concerns, there was clear evidence that this work was ongoing and that the provider is committed to achieving a high level of compliance to ensure the service provided was safe and effective. Whilst a number of improvements had been implemented a number of areas required ongoing improvement by the registered provider

The registered provider had ensured the appointment of a suitably qualified and experienced person in charge to the centre. This individual was supported in her role by a deputy person in charge. On the day of inspection no person participating in management was allocated to the centre with the recruitment process underway. The registered provider representative was actively involved in the governance of the centre. Clear communication pathways were in place within the governance team. Monthly governance team meetings were held to discuss any issues or concerns evident with a time bound action plan put in place to address these. All actions set were reviewed in following meeting

to ensure all actions set were completed.

One discussion that was observed in the minutes of the governance team meeting were the finding of the annual review of service provision and the unannounced inspection to the centre. The venue was utilised to ensure all members were aware of the actions out in place and the reports generated were utilised to improve service provision. The person in charge and team leader utilised a number of monitoring tools to ensure the day to day operations of the centre met the assessed needs of the residents.

Following the development and review of a staff supervision policy in October 2018, all staff members had now completed a formal supervisory meeting. A sample review of these were found to constructive with evidence of learning from same. Staff members were encouraged to participate in the improvements of the centre and in the day to day operations. For example the development of a staff handover sheet was developed by a member of the team following a discussion in supervision. A supervision meeting schedule was in place to ensure all staff received formal supervision in line with the organisational policy. Performance appraisals were also to be held on annual basis.

As part of all supervision meeting the training needs of staff were discussed. Whilst many staff had been supported and facilitated to attend training courses appropriate to their role within the centre. Improvements were required to ensure that new staff members received this training in a timely manner to ensure their role was completed in a safe effective manner.

The registered provider had ensured that sufficient staff were allocated to the centre. An actual and planned rota was in place which was reviewed regularly. This rota was currently under review to ensure that the current allocation of staff and shift pattern ensured the assessed needs of the residents. Nursing care was afforded the primary health care team or public health nurse as required.

There were no active complaints in the centre on the day of inspection. The organisational policy in place with regard to complaints had been reviewed in August 2018. This policy provided clear guidance for staff on procedures to adhere to should a complaint arise. this was currently under review due to the recent departure of the complaints officer. Residents spoken with could clearly articulate who they would speak to if they were not happy with something in their home,

Each individual had a signed contract of care in place. This written agreement ensured residents and their representative where applicable were aware of the service to be provided and any fees which were to be incurred.

Regulation 14: Persons in charge

The registered provider had ensured the appointment of a suitably qualified

and experienced person in charge to the centre.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had ensured the allocation of sufficient staff to meet the assessed needs of the residents. The actual and planned rota in place was currently under review.

Judgment: Compliant

Regulation 16: Training and staff development

Following the development and review of a staff supervision policy all staff have received a formal supervisory meeting with appropriate supervision in place.

Improvements were required to ensure all staff were supported and facilitated to receive appropriate training including refresher.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

All admissions to the centre were implemented in line with the statement of purpose. All residents now had a signed contract in place. this agreement included services to be provided including any fees to be incurred.

Judgment: Compliant

Regulation 3: Statement of purpose

The registered provider had ensured the development and review of the statement of purpose incorporating information as required under schedule 1.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had ensured that all notifiable events were notified to the office of the chief inspector in accordance with regulatory requirements.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had ensured the provision of an effective complaints procedure in the centre. Information and guidance of this procedure is clearly available to residents and staff.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider had ensured the development of policies and procedures under schedule 5 of the health act. However, improvements were required to ensure that these were reviewed in accordance with the allocated date.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had ensured the appointment of a clear governance structure to the centre whom through implementation of governance meetings had clear lines of communication.

Systems were in place for the ongoing monitoring service provision including an annual review of service provision and unannoucned visits to the centre.
Some improvements were required to ensure that improvements made to date were maintained and ongoing concerns were addressed in a timely manner.

Judgment: Substantially compliant

Quality and safety

The inspectors reviewed the quality and safety of the service provided within the designated centre. Residents are now consulted with the day to day operations of the centre. Residents were protected from harm and provided a safe and effective service. Whilst improvements had been made since the previous inspection was carried out further improvements were required in the area of healthcare for example to ensure that a high level of compliance was achieved and maintained.

The person in charge had ensured that each individual had an individualised personal plan in place. However, these were not of a consistent nature with respect to the quality of information present. A new template was currently in development to ensure that guidance was available for staff on procedures to adhere to ensuring the residents level of independence was encouraged and maintained. As a person centred planning meeting had not yet occurred for all residents individual goals were not always in place. Whilst residents were encouraged to participate in local and wider community activities these were not developed into future goals to promote a quality of life for residents. This was area of improvement which had been identified by the person in charge and team leader. A robust action plan was required to ensure that this issue is addressed in a timely manner ensuring that guidance is available for staff.

The registered provider had ensured that all residents were protected from abuse. A number of staff member had received training to complete the designated officer role and to provide guidance for staff should a concern arise. This guidance was utilised in conjunction with an organisation policy. Where a safeguarding concern had been identified a safeguarding plan had been developed. Improvements were required to ensure that these plans were reviewed in line with an allocated date to ensure that measures put in place were effective.

Risk was managed well within the centre. The person in charge had developed an environmental risk register which ensured the identification and assessment of identified risk. Whilst control measures had been implemented to reduce the impact of the risk and occurrence of the risk, improvements were required to ensure that these measures were reviewed to identify the requirement of any additional control measures or the effective of measures in place. This review should also incorporate the risk rating attached to the identified issues.

A full review had been completed of restrictive interventions utilised within the centre, to ensure that all restrictive practices were implemented in the least restrictive manner for the shortest duration necessary. Following this review their was reduction in restrictions in place. This review also incorporated the view of the residents. One restriction was requested to remain in place following consultation with individual a plan was in place to ensure that all restrictions were regularly reviewed with a plan in place to reduce the implementation of same.

Improvements were required to ensure staff had the skills and guidance to respond to behaviour that is challenging and to support residents to manage their behaviour. Where a behaviour of concern had been identified as requiring additional support, guidance was not available for staff to ensure that consistent approach utilised to support the individual. Due to lack of documentation or recording systems an trigger for behaviours had not been identified. The function of the behaviour had also not been identified. As guidance was not in place staff were not consistently implementing proactive strategies to reduce the occurrence of the behaviour and to reduce to anxiety to the individual. This required review.

Overall, residents were supported to achieve and maintain good physical and mental health. Whilst there was some difficulty accessing members so the multi disciplinary team the provider had implemented systems to maintain the well being of residents whilst awaiting consultation. Guidance for staff although available required review to ensure that all aspects of a person's physical well being was supported in accordance to best practice and in line with their capacity. Also, reviews to be completed to ensure that guidance available to staff is sufficient to meet the assessed needs of all individuals.

The person in charge had ensured that the use of medicinal products was done so in an effective manner. A full review had been completed of the procedures relating to the administration of products. This change to procedure and documentation had resulted in a reduction of medication errors which was evidenced through the implementation of medication audits.

Regulation 26: Risk management procedures

Overall risk was managed well within the centre.Systems in place ensured risk was identified and assessed in accordance with organisational policy. The system for review of risk required review to ensure the assessments in place were reviewed in accordance with allocated date.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had ensured that effective fire safety systems were in place. These systems included guidance for staff on the safe evacuation of residents in the event of emergency. Adequate precautions were in place including the presence of fire fighting equipment, daily and weekly checks.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge had ensured effective systems were in place for ordering, storage, administration and receipt of medicinal products.

Judgment: Compliant

Regulation 8: Protection

The registered provider had ensured through training and an organisational policy that residents were protected from abuse. Where a safeguarding concern arose safeguarding measures were implemented. Improvements were required to ensure that these measures were reviewed in line with allocated date.

As required clear guidance was available for staff to support residents with their personal and intimate care needs in a dignified manner.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The registered provider had ensured that the centre was operated in a manner that was respectful to the rights of the residents

Judgment: Compliant

Regulation 6: Health care

Whilst residents were afforded support to obtain health care from a number of allied health care professionals, guidance for staff on interventions to be carried out required review to ensure a consistent approach in accordance with best practice was adhered to by all

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured the development of individualised personal plans for each resident. However these were not consistent in nature, with varying levels of information present. annual reviews had yet to be completed with in some instances insufficient guidance for staff.

Judgment: Not compliant

Regulation 7: Positive behavioural support

A full review had been completed of restrictive interventions to ensure that all restrictive practices were implemented in the least restrictive manner for the shortest duration necessary.

Improvements were required to ensure staff had the skills and guidance to respond to behaviour that is challenging and to support residents to manage their behaviour.

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
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant

Compliance Plan for MooreHaven Centre OSV-0003723

Inspection ID: MON-0023933

Date of inspection: 02/04/2019

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 Person in Charge will ensure all staff including new staff members are appropriately trained in all mandatory training and any other training relevant to their role, including refresher training. The designated Centre is looking at:- a. a new management system in order to ensure compliance going forward, to support the Person in Charge; b. training up present staff members, in order to have our own in house trainers for mandatory training areas.	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: All policies for the Designated centre will be reviewed within the required time frame ,no less than on a 3 yearly basis or when required. The current review date will be amended, from an annual review date to a 3 yearly review date timeframe.	

Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: An audit schedule has been developed to ensure that quality improvement is maintained and that gaps are identified. When gaps are identified an action plan is developed to address them. Governance and management meetings are held on a regular basis. Compliance and quality improvement will be an ongoing agenda topic for these meetings in order to address any barriers to compliance and to ensure continuous quality improvement	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: All risk assessments have been reviewed and going forward will be reviewed in the required time frame. The risk management policy will be updated to reflect the appropriate review schedule.	
Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: All safeguarding plans will be updated within the required timescale. This will be achieved through the regular safeguarding meetings held with the PIC, Deputy PIC and the designated officer. These updated plans are then placed in the relevant individual's personal plan so as to guide the staff supporting the individual.	
Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: Health care plans are developed as a result of the annual health check or following	

review /consultation with a medical professional and when required these form part of the overall personal plan. Health care plans provide guidance for the staff members supporting individuals to ensure any recommendations from a health care professional are adhered to and best quality health care is provided. These health care plans are reviewed on a quarterly basis for ongoing health issues or when required for short term health issues or when there is a change in the presentation of an individual. The personal planning policy will reflect the review schedule for health care plans

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
To ensure all residents are supported to have goals that promote participation in the wider community and development of independence in line with their wishes, all residents will have a PCP meeting using the new model of PCP by July 31st 2019. A PCP review will be held on a quarterly basis to ensure the goal achievement is on track and to overcome any barriers that may have arisen. As a result of these meetings the relevant support plans will be updated. All support plans will be reviewed on a regular basis to ensure clear guidelines are in place in order for staff to provide the support required by each resident. Personal plans will continue to be audited to ensure a high standard is achieved for all residents. A Personal planning policy is in development to guide the residents, their families and the staff through the process. Training will be provided to staff regarding the new policy and the new personal planning process. Meetings have been held with the residents to discuss their requirement for easy read/accessible personal plans. For the residents who requested their support plans in this format they have been developed and are now part of the overall personal plan. To ensure that all residents are happy with the accessibility of their personal plans, it will be discussed again with them and if more accessible plans are requested these will be developed.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Individual behaviour support plans will be developed for residents where appropriate by 31st July 2019. The purpose of these plans will be to guide staff in the support of residents who demonstrate behaviours of concern in order to achieve a consistent and safe approach to the support the resident requires. These plans will be reviewed on an

ongoing basis. The designated centre will continue in its efforts to access multidisciplinary supports to support these plans.

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	26/07/2019
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	26/07/2019
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to	Substantially Compliant	Yellow	13/06/2019

	in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.			
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 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.	Substantially Compliant	Yellow	13/06/2019
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	26/07/2019

Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	31/07/2019
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/07/2019
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Not Compliant	Orange	19/08/3019
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in	Substantially Compliant	Yellow	31/07/2019

	needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	31/07/2019
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	19/08/2019

Regulation 05(7)(b)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the rationale for any such proposed changes.	Substantially Compliant	Yellow	31/07/2019
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Substantially Compliant	Yellow	19/09/2019
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Not Compliant	Orange	31/07/2019
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	31/07/2019
Regulation 07(4)	The registered provider shall ensure that, where restrictive	Not Compliant	Orange	31/07/2019

	procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	31/07/2019
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	31/07/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	26/07/2019
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the	Substantially Compliant	Yellow	26/07/2019

	prevention, detection and response to abuse.			