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:	St. Anne's Residential Services - Group M
Name of provider:	Daughters of Charity Disability Support Services Company Limited by Guarantee
Address of centre:	Tipperary
Type of inspection:	Unannounced
Date of inspection:	08 May 2019
Centre ID:	OSV-0005162
Fieldwork ID:	MON-0023915

About the designated centre

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

St.Anne's Residential Services Group M is a residential home located in Co.Tipperary. The service currently provides residential supports to five persons over the age of eighteen with an intellectual disability with a capacity for six individuals. The service operates on a 24 hour seven day a week basis with all supports implemented in line with the assessed needs of residents. Staffing levels as set out in the statement of purpose are two staff during waking hours and sleep over support in place at night. The home presents as a warm homely environment with each residents have their own bedroom space which is decorated in place with their personal tastes and interests. The house is a three story building with adequate recreational space available for residents. A person in charge has been appointed to the centre by the registered provider to ensure a safe and effective service is afforded to residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
08 May 2019	08:30hrs to 16:30hrs	Laura O'Sullivan	Lead

Views of people who use the service

The inspector met with all residents on the arrival to the centre. Residents were observed preparing for their trip to the day service which staff were supporting them to attend. One resident was sitting on their favourite chair in the dining room watching their favourite show, which they have to watch completely before starting their day. Another was relaxing in the living room watching their favourite morning programme.

So as not to disturb the residents chosen morning activity, the inspector spent time with one resident who showed them around their bedroom. They proudly showed off their artwork, some of which had been displayed on the wall in the centre and in their day service. The resident spoke of how they enjoyed living in the centre but didn't always like how one of their peers spoke to them. The interaction spoken of had been observed by the inspector on arrival to the centre. They did articulate that they always spoke to staff if they became upset by this issue, but still didn't like it.

When one resident did speak abruptly to a number of residents staff did not intervene. Guidance set out in behaviour management guidelines were not adhered to. One resident told their peer to be quiet and another walked past not interacting with peer when engaging in the behaviour. One resident did speak to the inspector of their upset due to this behaviour.

Two residents showed the inspector where the tea and coffee was in the kitchen and told them to help themselves during the day. Staff were observed supporting residents to commence their day in a positive manner encouraging independence and use of their skills. When one resident could not find their bag, a plan was discussed to look for this on return to the centre in the afternoon. Staff ensured that resident was happy and understood this plan.

Residents were all supported by staff to attend their local day service and said goodbye to the inspector before leaving for their day.

Capacity and capability

The inspector reviewed the capacity and capability within St. Anne's Residential Services Group M and overall a good level of compliance was evident. Through a well defined governance structure and clear lines of accountability, monitoring systems were utilised to drive service improvement. Measures were put in place which promoted this strive towards adherence to regulation. Some improvements were required however, to ensure all areas of concern were actively identified and

addressed in a timely manner.

The registered provider had appointed a suitably qualified person in charge to the centre. This individual possessed a clear understanding of the needs of the residents and had an oversight to the broad needs of the designated centre. Their knowledge incorporated the needs of staff to encourage an effective workforce. The person in charge was supported in their governance role by an appointed team leader. The team leader had been allotted a portion of time to complete administrative duties for the centre. There was clear evidence of communication within the centre level governance arrangements with a clear oversight of service provision needs. The roles and responsibilities of all members of the governance team both organisationally and centre level were in place with clear lines of accountability.

Communication was also evident throughout the governance structure. Members of the staff team completed a daily handover to ensure all staff were aware of the needs of the resident and centre on that particular day. For example, any prearranged appointments or social activities. This was reviewed by the team leader and the person in charge to ensure the appropriate staffing level and skill mix was allocated to the centre. A weekly report was forwarded to the person participating in management to the centre and senior management to ensure resources required were allocated to the centre and to ensure oversight of the needs was maintained.

Overall, the registered provider had ensured effective systems were in place for the monitoring of the centre. This included at organisational level the implementation, by a delegated person, an annual review of service provision. Within this review the provider was assured that the service was safe, well-resourced and person centred. Residents and their representatives were consulted as part of the review. It was implemented in consultation with six monthly unannounced visits to the centre. Both monitoring systems were comprehensive in nature and identified a number of areas of improvements.

Centre level monitoring systems ensured that members of the workforce were aware of their role and drove service improvement. These included daily fire checks, hygiene audits, drug recording audit and medicines audit checklist. Whilst action plans were in place for a number of identified areas such as person centred planning and premises. Improvements were required to ensure all areas requiring improvements were identified in a timely manner. For example, a number of written policies and procedures had not been reviewed within three years to guide best practice for staff; this had not been identified at centre level with no plan in place to ensure staff were aware of best practice. Non-compliance with respect to a number of regulations had not been self-identified by the governance team. For example, the compatibility of residents and impact of behaviours of concern on others.

The person in charge had systems in place to ensure the staff team were supported to raise concerns and discuss any issues relating to the operations of the centre. Regular team meetings occurred and staff were facilitated to participate

in formal supervisory meetings. Further developments of the training matrix within the centre was required to ensure that all staff were supported and facilitated to access appropriate training including refresher training. The registered provider had deemed a number of training courses mandatory to provide appropriate supports to residents however, a number of these training needs were outstanding. For example, supporting residents whom present with behaviours of concern and food safety preparation.

The registered provider had made available an effective complaints procedure for residents which was in accessible format. Staff were guided on the procedures to adhere to should a complaint arise through an organisational policy. This policy incorporated the contact details of the delegated complaints officer. This information was clearly visible within the centre to support residents should the wish to submit a complaint.

Regulation 14: Persons in charge

The registered provider had appointed a suitably qualified and experienced person in charge to the centre. This person had a clear understanding of their regulatory role and responsibility.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had ensured the number and skill mix of allocated staff to the centre was appropriate to the assessed needs of the residents.

An actual and planned roster was in place and reviewed in accordance with the requirements of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had not ensured that all staff had access to appropriate training including refresher training.

Supervision was provided for staff on a regular basis in accordance with local policy.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had ensured the appointment of a clear governance structure within the centre. Through clear lines of communication all members of the governance team were aware of their roles and responsibilities.

Through monitoring systems a number of areas for concern were identified with actions put in place to address same in a timely manner. Some improvement was required however, to ensure all areas of improvement were identified to ensure adherence to the regulations.

A comprehensive annual review had been implemented in conjunction with six monthly unannounced visits to the centre. These incorporated consultation with residents and their representatives to facilitate service improvement.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The registered provider had prepared in writing a statement of purpose containing the information as set out in Schedule 1.

Judgment: Compliant

Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent

The registered provider had ensured the notification of the procedures and arrangements for a period of absence for the person in charge.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had ensured the development of clear procedures to adhere to should a complaint arise. These procedures were incorporated in a local complaints policy which included the details of the delegated complaints

officer. Staff were aware of the procedures to adhere to.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider had developed polices and procedures as required under schedule 5. However, a number of these had not been reviewed at intervals not exceeding three years to ensure the service provided was in accordance with best practice.

Judgment: Not compliant

Quality and safety

St. Anne's Residential Services Group M presented as a positive centre where participation in meaningful activities was encouraged and facilitated by staff. Residents were actively participating in the local community and were well known valued members of society. Participation in personal interests was promoted including one residents personal shed in the garden to encourage their love of drums and another resident's love of art. Residents were consulted in the day to day operations of the centre through regular house meetings where residents were afforded the opportunity to discuss the running of their home.

The person in charge has ensured the development and on-going review of comprehensive and individualised personal plans. The personal plan review and completion was overseen by an appointed key worker with their responsibilities clearly set out. For example, ensuring information was up to date and relevant. A multi-disciplinary review of residents support needs occurred annually with any recommendations or guidelines recommended set out in plan to guide best practice of staff. A number of support needs were addressed to ensure a holistic approach was promoted with monthly service user meetings occurring to reflect any changes or participation in social activities.

Through participation in the annual person centred planning process residents were consulted in the development of their personal goals for example participation in local baking classes in the local community. Participation in goals was clear and progression was evident. Some improvement was required to ensure that goals were clear and all staff were aware of goals in place. For example, one goal to increase community participation through attending a baking course focused on activities within the house. Residents were supported to participate in a range of activities in the local and wider community with residents actively engaged in the

local GAA club and church.

One resident spoke with the inspector and informed them they did not like how one peer spoke to them and how it made them upset. This was observed by the inspector on arrival to the centre. A peer spoke abruptly to the individual repeatedly with foul language directed towards the person. Staff members present did not intervene as per the behaviour management guidelines in place and the behaviour did not cease until the resident left the dining room. These guidelines directed staff to intervene and redirect unfamiliar persons which may be a trigger to increase negative vocabulary and to encourage breathing exercise to reduce anxiety. The resident did articulate that they could speak with staff but that this behaviour happened often and they didn't like it. Upon review the incident had not been documented in either resident's daily notes, only that the resident used foul language in front of the inspector. It had not been noted that this behaviour of concern had been directed at peers or that it had caused distress. No safeguarding plan was in place to protect residents from such safeguarding matters and no evidence of ensuring local and national policy of safeguarding vulnerable adults from all forms of abuse was implemented. The person in charge assured the inspector that this was to be implemented however; no notifications were received by HIQA following the inspection (as is required).

Whilst behaviour support guidelines were in place for a number of identified behaviours, guidance was not always in place. For example, staff were not provided with clear guidance should a resident make an allegation against staff or peers, which was an identified behaviour. Due to this lack of guidance, there was an inconsistent approach to supports. Incidents were recorded in different manners and in differing documents within the personal plan. When the resident did make an allegation, clear evidence of follow through was not always clear and how the incident was responded to and supported. This differed depending on the staff member present. Hence there was an absence of appropriate guidance and as a result, and inconsistent approach.

Where a restrictive practice was utilised this was in place to promote the safety and well-being of residents. There was clear evidence of review of restrictive practices with measures put in place to review these on a regular basis. Where the reduction it the use of a restrictive practice increased the anxiety of one resident this was reintroduced.

Although the registered provider had ensured effective fire safety management systems were in place within the centre some improvements were required to ensure that containment measures present were utilised according to best practice. Residents were observed using chairs and other objects to hold fire doors open, reducing the effectiveness of the fire doors, there was no evidence of skills training or discussions relating to same. Effective systems were in place regarding the detecting of fire with fire fighting equipment serviced by a competent person on a quarterly basis. This was completed in conjunction with daily and weekly check of fire systems in place by staff including the fire panel and emergency lighting. Staff were afforded with clear guidance on the evacuation procedures to ensure residents

were evacuated form the centre in the safest manner.

The registered provider had ensured that effective systems were in place for the identification, review and assessment of risk within the centre. An environmental risk register was in place which incorporated a range of identified risk including lone worker environment, slips, trips and falls, and medication administration, the resident's use of their "drum shed". The person in charge ensured that all staff were aware of the identified risks and the current control measures in place to address same and minimise the likelihood and impact of the risk. However, upon review the current control measures were not always in place and required further review. For example, within a risk assessment addressing the area of behaviours of concern and within the lone working risk assessment an identified current control measures was the training of all staff in the area of behaviours of concern. However, this was not being implemented as a number of staff had not yet received training in this area.

Regulation 13: General welfare and development

Participation in meaningful activities was promoted within the centre. Residents currently residing in the centre attended a local day service.

Community involvement was facilitated and promoted with residents actively engaging in the local and wider community.

Judgment: Compliant

Regulation 17: Premises

The design and layout of the building met the current assessed needs of the residents. The premises were warm and homely with each individual having their personal bedroom which they decorated to their unique taste and interests.

The centre was in a good state of repair both internally and externally.

Judgment: Compliant

Regulation 26: Risk management procedures

Whilst the person in charge had effective systems in place for the ongoing identification, assessment and review of risk. Improvements were required to ensure that all current control measures in place were implemented.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Whilst effective fire safety management systems were in place within the centre with systems in place for the ongoing review of fire fighting equipment and means of escape.

Some improvements was required with regard to skills training for residents regarding the use of fire containment measures to ensure that these were utilised in accordance with best practice.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured the development and regular review of comprehensive individualised plans. Where applicable multi disciplinary input was evident with clear guidance for staff on a plethora of support needs.

Residents were consulted through the implementation of person centred planning meetings, which incorporated the planning and review of personalised goals. Some improvements were required to ensure that goals set were clear.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The person in charge had not ensured that staff had up to date knowledge and skills appropriate to their role, to respond to behaviours that is challenging and to support residents to manage their behaviour.

Where restrictive practice is in place, such procedures are applied in accordance with local and national policy.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had not ensured that all residents were protected from all forms of abuse. Where residents were at risk of abuse safeguarding measures were not in place.

Clear guidance was not available for staff on procedures to adhere to should a resident make an allegation against staff or peers.

Judgment: Not compliant

Regulation 9: Residents' rights

The centre was operated in a manner which encouraged the participation and consultation of residents. Some improvements were noted to ensure that concerns raised by residents were addressed in a timely manner and that measures were in place to ensure their dignity was respected in their personal living space.

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
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 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for St. Anne's Residential Services - Group M OSV-0005162

Inspection ID: MON-0023915

Date of inspection: 08/05/2019

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: Since inspection the Person in Charge and the training department have booked in all identified staff members to complete their refresher training. This will be completed by September 2019.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Since inspection the Person in Charge has ensured that the audit folder has the most up to date audits in place with risk assessment review to reflect Studio 3 training and all action plans from audits are now complete.	
Regulation 4: Written policies and procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies	

and procedures: Since inspection the Person in Charge has ensured the most up to date policies available are within this centre's policy folders and a schedule for service wide policy review is in progress.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Since inspection the relevant risk assessment has been updated to include all additional measures for Studio 3 training to be provided to all staff. All staff in this centre will have their training needs met by quarter 3 2019.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Since inspection the Person in Charge has met with the residents to explain the importance of keeping their bedroom doors which are fire doors closed at all times. This is also discussed at the weekly advocacy meeting and staff monitor same on a daily basis. One resident is being encouraged to maintain his own records in relation to complying with this request.

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: Since inspection the staff team have been met by the Person in Charge to ensure that they record all information accurately and in the appropriate sections of the relevant individuals plan of care. This will be further discussed at the house meeting to be held on 25/07/2019.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Since inspection the staff team have been met by the Person in Charge to ensure that they record all information accurately and in the appropriate sections of the relevant individuals plan of care. This will be further discussed at the house meeting to be held on 25/07/2019. The Person in Charge will go over the behaviour support plan with the staff team to ensure all are aware of its contents with a view to ensuring adherence going forward. The Person in Charge will further discuss with the psychologist some additions to the behaviour support plan to support individual in relation to their specific needs.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Since inspection the Person in Charge has discussed with the staff team the importance of ensuring clear documentation is maintained within the relevant residents care plan.
Following the incident on the day of inspection a safeguarding meeting was held 09/06/2019 and a notification was sent to HIQA Not-0213607 and a follow up notification was sent on the 28/06/2019.

In relation to the resident specified in the report her PIC to arrange MDT to review the resident's current communication plan and contract regarding making false allegations.

Preliminary screening meeting took place on 09/05/19 and an interim safeguarding plan devised. A formal safeguarding plan was held 05/06/2019, and the plan was reviewed and updated.
PIC to re-submit NF06 notification to include all details relevant to the incident.
A risk assessment to be completed in relation to the risk to each individual resident arising out of the challenging behaviour of PCC.
Keyworkers to check in weekly with residents as to how they are feeling and any issues arising, to record their responses and to support them to inform staff if they have concerns. Management are to be informed issues as they arise.
All residents care plans will be updated regarding their supervision guidelines when in each others company.
Support for all Service Users: there are weekly advocacy meetings in the house where dignity and respect is discussed when all service users are reminded to speak nicely to one another.

A social story has being put in place, regarding talking nicely to each other
Safeguarding policy in place and staff training completed by all staff. MDT involved with all residents as required. Regular team meetings are held and safeguarding issues are discussed. Inaccuracies in documentation recording were discussed at team meeting held on 25/07/19.
All staff to have managing challenging behaviour training completed. staff will complete same in September 2019.
A transition plan has been in place for the resident to transfer to another residential placement, with ladies of similar age, as requested by resident and their family.
Transition plan commenced, following discussion at ADT meeting and MDT held on 20/06/19 in relation to transfer to new placement and was approved and agreed.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Since inspection the Person in Charge will reiterate the contents of the behaviour support plan to the staff team and the importance of all follow up documentation in relation to the individuals impacted as a result of incidents. This will be further discussed at the house meeting on 25/07/2019.

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	30/09/2019
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	31/08/2019
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	30/09/2019
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	Substantially Compliant	Yellow	31/08/2019

	aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.			
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.	Not Compliant	Orange	30/09/2019
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	31/08/2019
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	31/08/2019
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	31/08/2019
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	Substantially Compliant	Yellow	31/08/2019

	intervention techniques.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/08/2019
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	31/08/2019
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Substantially Compliant	Yellow	31/08/2019