Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Kinnegad Centre
Name of provider:	Muiríosa Foundation
Address of centre:	Westmeath
Type of inspection:	Announced
Date of inspection:	15 October 2024
Centre ID:	OSV-0005824
Fieldwork ID:	MON-0036583

About the designated centre

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

Kinnegad Centre is a dormer bungalow located approximately 2km from the local town. Kinnegad Centre is a full time community house which is based on a social model of support. The building design is currently suitable for individuals with high support needs and can accommodate four individuals. There are five bedrooms, four downstairs and one upstairs. The bedroom upstairs is used as a staff sleepover room. There is a large entrance hall and wide corridors. There is an open plan kitchen and dining, a utility, and a sitting room. To the rear of the house is a large fenced garden with patio area and a lawn area to the front of the house. All entrances are wheelchair accessible. Services are provided from the designated centre to both male and female adults. 24 hour support is provided by staff.

The following information outlines some additional data on this centre.

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 (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
Tuesday 15 October 2024	10:45hrs to 18:20hrs	Julie Pryce	Lead

What residents told us and what inspectors observed

This inspection was conducted in order to monitor on-going compliance with regulations and standards, and to help inform the registration renewal decision.

There were three residents living in the centre on the day of the inspection, and the inspector met all three of them. The designated centre is a bright and airy house, with all the residents" accommodation on the ground floor. The house was nicely furnished, and was well decorated and maintained with the exception of some damage to the hallway flooring. However, this had been identified by the person in charge, and a maintenance request had been submitted.

On arrival at the centre, the inspector met one of the residents who was on their way out to an activity. The resident was totally focused on their outing, and did not interact with the inspector however, the inspector observed staff to be supporting them and communicating with them as they made their preparations.

Another resident returned home later in the day from their activity, and the inspector could hear them having a lively chat with staff members, and telling them all about their day. They came in and briefly met the inspector, but chose not to interact any further. Staff explained that they were shy of new people at first. The resident went off to the kitchen with the staff, and could be heard continuing the chat and having banter with the staff. It was evident that they were familiar and comfortable with these staff members.

The third resident had a chat with the inspector with the help of staff support, and spoke about their fondness for animals. They helped care for a neighbour's cat who came to visit the house, and bought cat food for it. There were also dogs at their day service sometimes. They did, however, explain that the vocalisations of one of the other residents' disturbs them, and were quite clearly expressing that this was a problem for them.

A review of the records maintained in the designated centre indicated that, residents were supported to have active and meaningful lives, and that they were offered support in accordance with their preferences. For example, one of the residents had a one-to-one staff member in relation to safe mobilising, and they would frequently decide that the staff member allocated to them was not the person of their choice on the day, and a change of staff was always facilitated.

Choices were also facilitated and supported in various other ways, both at the regular residents' meetings, and on an individual basis. Residents chose their meals and snacks, their activities and their clothing.

Residents had been supported to complete HIQA (Health Information and Quality Authority) questionnaires with the support of staff, and a recurring theme was, the disturbance caused by the loud vocalisations of one of the resident's. This was the

only issue raised by residents, who otherwise indicated that they were happy with all other aspects o their lives in their home.

There were two recently documented compliments received by the service, one from a family member and one from a resident relating to a video that had been recorded by staff, of them enjoying particular activity that had been shared with their family.

Overall, residents were supported to have a comfortable and meaningful life, with an emphasis on supporting choice and preferences and there was a good standard of care and support in this designated centre. Notwithstanding, some improvements were required in the management of restrictive interventions and in the storage availability in the home as further discussed under regulations 7 and 9 of this report.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

There was a clearly defined management structure in place, and lines of accountability were clear. There were various oversight strategies which were found to be effective in the most part, with some improvements required local auditing.

There was an appropriately qualified and experienced person in charge who was involved in the oversight of the centre and the supervision of staff.

There was a competent staff team who were in receipt of relevant training, and demonstrated good knowledge of the support needs of residents, and who facilitated the choices and preferences of residents.

There was a clear and transparent complaints procedure available to residents.

Regulation 14: Persons in charge

The person in charge was appropriately skilled and experienced, and was involved in the oversight of the centre. It was clear that they were well known to the residents, and that they had an in-depth knowledge of the support needs of each resident.

Judgment: Compliant

Regulation 15: Staffing

There were sufficient numbers of staff to meet the needs of residents both day and night. A planned and actual staffing roster was maintained as required by the regulations. There was a consistent staff team who were known to the residents.

The inspector spoke to the person in charge and two other staff members during the course of the inspection, and found them to be knowledgeable about the support needs of residents. Staff were observed throughout the course of the inspection to be delivering care in accordance with the care plans of each resident, and in a caring and respectful way.

Judgment: Compliant

Regulation 16: Training and staff development

All staff training was up to date and included training in fire safety, safeguarding and infection prevention and control.

There was a schedule of supervision conversations maintained by the person in charge, and these were up to date. The person in charge had conducted additional supervision conversations following an incident of an unexpected fall.

The inspector viewed three of the records of supervision conversations, and saw that there was a review of personal developments and that any learning needs were identified together with the staff member.

Judgment: Compliant

Regulation 19: Directory of residents

The provider maintained a directory of residents which included the information specified in paragraph (3) of Schedule 3 of the regulations.

Judgment: Compliant

Regulation 23: Governance and management

There was a clear management structure in place, and all staff were aware of this

structure and their reporting relationships. The person in charge was supported by a team lead every day.

Various monitoring and oversight systems were in place. Six-monthly unannounced visits on behalf of the provider had taken place and an annual review of the care and support of residents had been prepared in accordance with the regulations. The annual review was a detailed report of the care and support offered to residents. The inspector reviewed a sample of required actions form these processes, and found that they had all been completed. These actions included an update of goal setting for residents, a review of hospital passports and the requirement for the inside of the house to be repainted. All of these had been completed within their identified timeframes.

A range of audits had taken place, for example, audits of safety in the environment, of medication management and of residents' finances. However, these were all self-audits conducted by staff members, and all consisted of ticking off items in a list. There was no evidence to support the findings, so that the inspector was not assured that this was a meaningful monitoring process.

However, a detailed audit of infection prevention and control was conducted on a monthly basis, and this audit included comments to support the findings, even if no failings were identified.

Regular staff team meetings were held, and the inspector reviewed the minutes of the last two of these meetings. The items for discussion included update on residents, any accidents or incidents, residents meetings and various other aspects of care and support in the centre. It was evident that these were useful and meaningful meetings, however, while there was a sign in sheet for staff who were unable to attend the meeting to sign to confirm that they had read the minutes, this was not monitored, and had not been completed for either of the last two meetings.

Daily communication with staff was well managed via a verbal and written handover at the change of each shift, and a diary for reminders and appointments.

Communication with senior management was enhanced by the preparation of a monthly 'Regional management governance report' which was prepared by the person in charge and submitted to the person participating in management. This report included an overview of any medication errors, health appointments, restrictive practices and staffing and it was clear that senior management were kept well informed.

Overall, staff were appropriately supervised, and the person in charge and senior management had good oversight of the centre, although improvements in auditing were required.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure available to residents and their friends and families. The procedure had been made available in an easy read version and was clearly displayed as required by the regulations.

Whilst there had been no complaints, a complaints log had been prepared whereby the complaint would be recorded together with the actions taken, and a record of whether the complainant was satisfied with the outcome.

Judgment: Compliant

Quality and safety

There were systems in place to ensure that residents were supported to have a comfortable life, and to have their needs met. There was an effective personal planning system in place, and residents were supported to engage in multiple different activities.

The residents were observed to be offered care and support in accordance with their assessed needs, and staff communicated effectively with them.

Healthcare was effectively monitored and managed and changing needs were responded to in a timely manner.

Fire safety equipment and practices were in place to ensure the protection of residents from the risks associated with fire, and there was evidence that the residents could be evacuated in a timely manner in the event of an emergency.

There were risk management strategies in place, and each identified risk had a detailed risk assessment and management plan.

Where residents required positive behaviour support there were detailed behaviour support plans in place, however staff had not been in receipt of training in the management of behaviour that is challenging. Improvements were required in the implementation of restrictive practices, both to ensure that they were effective and that they were consistently applied and recorded.

The rights of the residents were well supported, and residents indicated that they were happy in their home, with the exception of being regularly disturbed by the vocalisations of one of the residents. . Staff were knowledgeable about the support needs of residents and supported them in a caring and respectful manner.

Regulation 10: Communication

Communication with residents was given high priority in the centre and each resident had a 'personal communication passport' which included information about the ways in which residents communicated in a non-verbal way, and the best ways for staff to communicate with them.

These passports included information personal to residents, such as throwing the ball meant 'I'd like to play' for one resident, and there was information about different vocalisations and their meanings.

Various innovative ways of giving residents information had been explored, for example staff were using online videos about personal care to support residents to increase their independence, and had supplemented these with easy-read information.

The inspector observed staff communicating with residents, and saw that they responded appropriately to their non-verbal communication. Staff explained with confidence, the ways in which people indicated choices, and the inspector found that this was a topic of discussion at team meetings.

Judgment: Compliant

Regulation 13: General welfare and development

Each resident had a person centred plan which was based on a detailed assessment of need. The plans included guidance for staff as to the way in which to ensure that residents were supported to optimise their opportunities, for example the need or familiar staff, or the need to ensure that a bathroom was readily available in the community.

Residents were involved in a range of different activities both in their home and in the community, in accordance with their preferences. Activities included art classes, attending mass and meals out. Some residents enjoyed activities at home, such as being involved in cooking.

Residents were supported to set goals as part of the personal planning process, and these were individual to each of them. For example one resident was being supported to use a tablet to support their communication.

The inspector found that residents were being supported to have a meaningful day in their individual ways.

Judgment: Compliant

Regulation 17: Premises

The designated centre was well maintained and decorated, and each resident had their own private room. There were adequate communal and private areas, and functional outside garden areas for the use of residents. The communal areas were bright and airy, although as further discussed under regulation 9, the high ceilings and echoing nature of the environment was not conducive to the quiet environment that some residents preferred.

There were some maintenance issues, including scuffed and damaged floors in the front hall, however, the person in charge provided maintenance requests, so that it was clear that this had been identified and was in the process of being managed.

However, there was insufficient storage in the designated centre as required by the regulations. For example, the inspector found that the bedroom of one of the residents had a number of pieces of equipment in the room, including safety crash mats propped up against a wall, a mobilisation aid and a wheelchair. This made the room appear clinical and did not look like the bedroom of a resident.

In the room of another resident, personal effects were stored on boxes on top of the wardrobe, together with items of luggage. There was no storage in the bathroom available to residents for toiletries as all available space was taken up with incontinence wear, which was not required for all the residents who used the bathroom. Schedule 6 of the regulations requires the provider to ensure sufficient storage for each resident, and the inspector found that the arrangements were not adequate to meet this requirement.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There was a current risk management policy which included all the requirements of the regulations. Risk registers were maintained which included both local and environmental risks, and individual risks to residents. There was a risk assessment and risk management plan for each of the identified risks.

Local risk management plans included the use of the overhead hoist, staffing levels and fire safety. Control measures in place to mitigate these risks were clearly identified and staff spoke about their role in ensuring that they were implemented.

Individual risk assessments included the risk of falls, the risk associated with a resident making false accusations and the risk relating to the management of epilepsy. The risk management plan relating to epilepsy for one resident included detailed control measures such as the use of head protection, specific footwear and

medication management. The inspector read the risk management plan relating to skin integrity, and observed that the control measures including an air mattress were in place.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had put in place various structures and processes to ensure fire safety. There were self-closing fire doors throughout the centre and all equipment had been maintained. Regular fire drills had been undertaken, and there was a personal evacuation plan in place for each resident, giving guidance to staff as to how to support each resident to evacuate.

Fire drills were documented, and any learning from fire drills was documented, together with any learning. For example, where a resident had been reluctant to evacuate during a drill, there was information as to how to reassure them, and it was clear to the inspector that all residents could be evacuated in a timely manner in the event of an emergency.

Judgment: Compliant

Regulation 6: Health care

Healthcare was well managed, and both long term conditions and changing needs were responded to appropriately. There had been two recent changes in the presentation of residents that had been responded to in a timely manner. Staff had noticed a change in the breast of one of the residents and this had been immediately referred for investigation. Another resident had been observed to have a change in eating habits, and again this had been immediately referred to the residents' general practitioner, and treatment for an infection had been implemented.

There were detailed healthcare plans in place, for example in relation to epilepsy and nutritional needs. Three was evidence that these care plans were implemented, and the interventions were recorded daily where appropriate, with the exception of the ambiguity in relation to the management of seizure activity for one of the residents as discussed under regulation 7 of this report.

Residents had access to various members of the multi-disciplinary team (MDT) as required. Health screening had been offered to residents, and either implemented or considered and ruled out.

The inspector was assured that healthcare was given high priority in this designated

centre, and that all efforts had been made to ensure that information was made available to residents.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where residents required positive behaviour support, there were detailed plans in place, based on a detailed assessment of needs. A function or rationale of the behaviours of concern had been identified, based on a detailed history. Proactive strategies were clearly identified, including preferences of the resident, for example, that they prefer to get up early and have a chat. Reactive strategies were outlined, including such measures as 'using a playful tone of voice' and 'avoiding over explaining'. The behaviour support plans included detailed information about communication with the resident, including non-verbal strategies in relation to redirecting. Staff were knowledgeable about the guidance in the behaviour support plan, and described their role in reducing the frequency and severity of behaviours of concern.

Some improvements required in the monitoring of restrictive practices. For example, an identified risk to one of the resident was of seizures during the night. The current practice was to conduct 15 minute checks on the resident during the night. However, there was insufficient evidence that this was either necessary or effective.

For example, the person in charge and the staff could not explain how this would be effective if the resident had a seizure immediately after one of these checks, given that it would be another 15 minutes until the next check. It was documented that 'staff had very little faith in the epilepsy monitor', which indicated that the 15 minute checks related more to the anxiety of staff than to the safety of the resident. There was a suggestion that this monitor had failed to alert staff, but there was no documentary evidence of this in the records maintained in the designated centre.

In addition, the 15 minute checks were not recorded contemporaneously as required, and while there was an expectation that the checks would be recorded on the daily notes each day, the inspector found only one reference to these checks in the week from 7 October to 14 October 2024.

The epilepsy alert monitor was not included in the register of restrictive practices other than a comment under the column entitled 'interventions tried and considered'. In addition, the minutes of a staff meeting held on 25 August 2024, it was stated that 'when the seizure monitor stops working, it will not be replaced'. This monitor had been prescribed by the resident's neurology team.

The inspector was therefore not assured that there was a clear plan in place to manage the risk, or to apply restrictions in accordance with best practice.

Furthermore, staff members had not been in receipt of training in the management

of behaviour that is challenging including de-escalation and intervention techniques.

Judgment: Not compliant

Regulation 9: Residents' rights

All staff had undertaken training in human rights, and staff engaged by the inspector spoke about the ways in which they were supporting residents to make their own decisions and to make choices.

One of the residents was supported in their fondness for animals and pets, whilst respecting the views of the other residents, so that their preference was accommodated by having access to pets as described in the first section of this report.

There were regular residents' meetings at which the week ahead was planned, and residents were supported to indicate their feelings about the previous week. The residents had been made aware of the forthcoming HIQA inspection at these meetings. In addition, there was a 'topic of the week' shared with residents. For example, at a recent meeting, the topic had been health.

It was evident that family involvement was supported, and record were maintained of contacts with family members.

There was an ongoing issue whereby the vocalisations of one of the residents which was disturbing other residents. The design of the designated centre meant that there were very high ceilings in the main living areas, which were open to the top of the two storey building. This created an acoustic effect of echoing any noise, so that vocalisations were amplified. This had been acknowledged by the person in charge, and various solutions such as additional doors were under discussion however, at the time of the inspection this issue had not been resolved.

Notwithstanding, overall the inspector found that the rights of residents were acknowledged and supported, and that any issues had been identified and acknowledged.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Kinnegad Centre OSV-0005824

Inspection ID: MON-0036583

Date of inspection: 15/10/2024

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The Person in Charge ensures that all staff that are not present at team meetings are presented with minutes to read/review in a prompt manner and will also review monthly to ensure that all staff are complying and are afforded the opportunity to give feedback or seek more information. • The Person in Charge reviews the monthly audits assigned to staff to ensure that there is an action plan present and a plan for completing all actions with an adequate timeframe identified. There is also an Audit schedule in place to ensure that staff and management have a clear schedule for completing the assigned audits.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • The Person in Charge has identified an area for storage of any manual handling equipment that is not required to be stored in the resident's bedrooms. • Items belonging to residents that were being stored in the bathroom have now been removed and only brought in when required. Additional storage space for personal care items has been added to the residents' bedrooms and also a storage cabinet in the bathroom where personal care items can be stored discreetly. • Soft furnishings have been added to the sitting room area to reduce the echoing sounds in the large open space with the high ceilings.	

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• A multi-disciplinary team of Clinical Psychologist, Behaviour Therapist, Occupational Therapist, Person in Charge and PPIM conducted a review of Restrictive Practices. The existing 15-minute nighttime checks that were in place for one resident have been reviewed and discontinued.
• This resident has an Epilepsy monitor in place to alert staff of seizure activity. There is also a night duty staff in place to support residents.
• The Epilepsy monitor has been added to the Restrictive Practice register and will be reviewed at monthly meetings by the Person in Charge and also added to the Restrictive Practice Committee six- monthly review. Risk assessments have been updated and approval documentation is now in place.

• Staff have completed Crisis Intervention training on the 29/10/24 and 11/11/24.This will be part of training requirement for all new staff in the centre.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The main living areas have been provided with additional soft furnishings that have reduced the acoustic/echo effect of the open space and high ceilings.

• One resident can be vocal at times which may impact on the other residents.
This is a large spacious home where residents can be afforded quiet time in other areas of the house if required. Residents are always offered opportunities to participate in social outings. This will be reviewed at monthly meetings. There is a current referral to Occupational Therapy to assess the resident for sensory intervention supports to help reduce vocalisations. Any signs of anxiety or distress are documented and Behaviour support guidelines are in place.

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 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	01/11/2024
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	01/11/2024
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Not Compliant	Orange	29/10/2024
Regulation 07(4)	The registered provider shall	Not Compliant	Orange	18/10/2024

	ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	18/10/2024
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Substantially Compliant	Yellow	01/11/2024