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:	Group C - Community Residential Service Limerick
Name of provider:	Daughters of Charity Disability Support Services Company Limited by Guarantee
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	01 July 2019
Centre ID:	OSV-0003941
Fieldwork ID:	MON-0024978

About the designated centre

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

This designated centre is comprised of two houses in relatively close proximity to each other in a pleasant mature residential area within walking distance for some residents of a range of amenities, public transport routes and the provider's main campus. Each house is located on its own private site with gardens enjoyed by residents; one house is a bungalow while the other is a dormer style house. A total of eight residents live in the centre; five in one house and three in the other. Residents present with a diverse range of needs; the service delivered reflects this. For example one house is a busy house with residents leaving early each morning to attend a range of day services or paid employment. Residents with increasing needs perhaps in relation to increasing age or deteriorating health enjoy a slower pace of life in the other house.
The model of care is social with each house staffed by a team of social care staff led by the person in charge. Management and nursing support is available each day from the team of CNM's (Clinical Nurse Managers) based on the main campus.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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
01 July 2019	08:30hrs to 16:00hrs	Mary Moore	Lead

What residents told us and what inspectors observed

The inspector met with three residents; one in one house and two in the other; residents in both houses spend a large part of their day out of the house. The residents met with presented as confident, well and content. Residents spoke of their general well-being, the support received from staff and changes they had to make to their lifestyle so as to stay well. Residents spoke of their upcoming birthday and their plans to celebrate. How residents intended to spend their day was discussed and they were clearly looking forward to attending their respective day services.

The inspector noted that residents were at ease with the staff on duty and presented as in control of their plans and routines. The inspector spoke with staff and reviewed records such as the records of meetings held with residents to further inform how residents viewed and participated in the service that they received. The inspector found staff to be knowledgeable and respectful, clear on the challenges in the service and on what constituted a safe, quality service and home for each resident.

Capacity and capability

The overall finding of this inspection was that while there was a clear and effective management team responsible for the day to day management of this service, and generally residents received a good quality service, the provider had failed to adhere to and progress a plan submitted to HIQA (Health Information and Quality Authority); the centre had been registered in August 2018 with a condition attached requiring the provider to adhere to this plan. While various factors had impacted on the progression of this plan, the inspector was advised that the centre was not adequately resourced to deliver on aspects of the plan. The plan in summary consisted of the extension of one house to include a self-contained apartment in response to needs that were not compatible; the replacement of the other house due to the absence of a lease agreement and the completion of infrastructural works to contain fire and its products. The continuing failure to implement this plan impacted negatively on residents and placed limits on the quality and safety of the service received by five residents living in one house.

There were many indicators of effective governance. For example the local management team was comprised of suitably qualified and experienced managers who met and interacted on a daily basis. In addition formal management meetings and local staff meetings were convened and there were formal systems for supporting and supervising staff. The person in charge though recently appointed

had established experience in the service, a ready knowledge of regulatory requirements and of the provision of a safe, quality service. The person in charge however also worked as a frontline staff member with a weekly allocation of eight administration hours; this allocation was described as challenging to ensure the consistent and effective management of the designated centre. The inspector was advised that this had been escalated to senior management and was currently under review. Senior management were described as accessible and supportive.

There was clarity in practice on the stated purpose and function of the centre; the record setting out the purpose and function and other information such as staffing levels, complaints procedures, the visitors policy, was available in the centre and was recently reviewed. The record required further review and amendment however as it did not reflect recent changes in the governance structure; clarification was also needed in relation to staffing numbers and the whole-time equivalent (the number of staff that would be employed if all staff worked full-time).

The provider managed staffing resources to ensure that they reflected and adequately supported resident's individual and collective needs. For example additional staff resources were provided each morning and evening and all day at weekends in one house. Additional staff were provided in the other house on specific days or mornings to support residents to enjoy a slower but fulfilling pace of life. The staffing levels seen by the inspector were as advised; staff reported consistency of staffing and a limited number of relief staff who were known to residents.

The inspector reviewed training records to establish that staff were facilitated to complete mandatory, (for example safeguarding and fire safety) and required or desired training (such as medicines management and food safety) so that they could appropriately and safely respond to residents needs and perform their duties. There was full staff attendance at training with the exception of responding to behaviours of concern or risk; this is addressed in the next section of this report.

The provider had a suite a policies and procedures to guide and underpin the care and support provided and the general operation of the service, for example recruitment practice, complaints management, records management. The inspector saw that the provider itself was aware that some policies required review; this was referenced in the providers own reviews of the service from late 2018 and early 2019. The inspector was advised that the reviews of approximately five policies were almost complete and were awaiting final authorisation.

There were no recent or open complaints to be reviewed. The inspector was satisfied that this was correct and that the complaints procedure was accessible to residents. Records seen by the inspector indicated that management and staff regularly actively sought feedback from residents, clarified that they had no concerns and had raised no complaints.

The provider had many systems for reviewing the adequacy of the quality and safety of the service provided to residents such as the management and staff meetings referred to above, the presence of the person in charge in the designated

centre with direct access to residents and staff, and regular consultation with residents. The provider was also completing on schedule the annual and unannounced reviews specified in the regulations. The inspector reviewed the report from the most recent unannounced review undertaken in April 2019 and the annual review completed in December 2018. The inspector found the reviews to be comprehensive and transparent in that the provider did self-identify its own failure to progress and adhere to its own quality improvement plan and its own completion timeframes. The provider also acknowledged in these reviews the negative impact on residents of this failure and on the appropriateness, safety and quality of the service provided to them. However, the provider does not have a fully-funded, definitive and measurable plan to provide residents with security of tenure in homes that are appropriate to their needs and compliant with the fire safety requirements of Regulation 28.

Regulation 14: Persons in charge

The person in charge had the qualifications, skills and experience necessary to manage the designated centre. The person in charge facilitated the inspection with ease and had sound knowledge of the residents and their needs, of what a safe quality service was, and of the general operation and administration of the designated centre.

Judgment: Compliant

Regulation 15: Staffing

The provider maintained staffing levels and arrangements that were appropriate to the assessed needs of the residents. Residents received continuity of care and supports from a team of regular staff.

Where nursing advice and care was needed it was provided.

The person in charge maintained a planned and actual staff rota.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had completed mandatory training within the specified timeframes. Staff were

also provided with training that supported them to safely meet resident's needs and to perform their role effectively. Further training was needed in responding to behaviour of concern and risk; this is addressed in the next section of this report.

Judgment: Compliant

Regulation 23: Governance and management

The provider had failed to progress and adhere to its quality improvement plan and the completion timeframe as agreed with HIQA. The provider acknowledged this in its reviews and also acknowledged the consequent negative impact on residents and on the safety and quality of the service provided to them. The provider did not however have a fully-funded, definitive and measurable plan to provide residents with security of tenure in homes that were appropriate to their needs and compliant with the fire safety requirements of Regulation 28.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose and function did not reflect recent changes in the governance structure; clarification was also needed in relation to staffing numbers and the staffing whole-time equivalent.

Judgment: Substantially compliant

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

The provider was aware of and had notified HIQA in the prescribed format of absence and changes to the person in charge role and the arrangements for the management of the designated centre in these situations.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had policy and procedure on the receipt and management of complaints that was accessible to residents. The provider regularly consulted with residents, sought feedback from them and established that they were satisfied. While there were no complaints recorded the provider acknowledged the ongoing anxiety for residents due to the failure to progress plans for their relocation to their new homes.

Judgment: Compliant

Regulation 4: Written policies and procedures

While policy review was ongoing, the provider had failed to ensure that it reviewed each policy at a minimum every three years.

Judgment: Substantially compliant

Quality and safety

There were many positive aspects to this service and clearly positive outcomes for the residents living there. For example residents were supported on a daily basis by staff and management familiar to them, knowledgeable of their needs and respectful of their individuality. There were good arrangements for ensuring that resident's enjoyed the best possible health. Residents lived in and were part of their local and wider community. Residents were actively consulted with and listened to in relation to the general operation of the centre. However, while fundamentally the service provided on a daily basis was a quality service, the provider's failure to adhere to and progress its plan meant that there were ongoing restrictions and limitations on residents' quality of life and safety, individually and collectively; the purpose of the plan had been to address this.

Resident's abilities, needs, choices and preferences and the support and care they needed were set out in a well presented personal plan. Staff spoken with had ready knowledge of the contents of the plan and discussed with the inspector, for example monitoring tools that were used daily to ensure resident well-being and to assess the effectiveness of the plan. However, while the inspector was assured by the provider that each resident's plan was the subject of a multi-disciplinary review, this was not evident from the sample of plans reviewed. This was also noted during the providers own internal reviews.

The personal plan incorporated the plan for agreeing and establishing resident's personal goals and objectives. Residents participated in this process, their personal goals were progressed and achieved; their goals reflected their personal interests and how they wished to live their life. Overall the inspector found that all residents including those of advancing age and deteriorating health were supported to live full and meaningful lives. For example one resident had asked to travel to Lourdes and this was achieved with peers and staff as part of a community based pilgrimage. Staff described the planning of the trip to ensure that it was a success. There was shared joy and celebration of the success enjoyed by another resident at the recent Dubai Special Olympics. Residents participated in a broad range of community based activities and events and very much lived ordinary lives in the local and wider community.

The inspector found that residents were consulted with in a meaningful and inclusive manner in relation to the care and support that they received and the general operation of the centre and the service. This was evident in the provider reviews referred to in the first section of this report; the provider readily acknowledged in these reviews the anxiety experienced by residents as a result of the provider's delay in progressing this plan. The inspector also reviewed the records of meetings held between staff and residents on a monthly basis. Items discussed included changes to the governance structures, updates on the plans to relocate, the findings of HIQA inspections and internal reviews; staff actively sought feedback from residents and provided feedback on residents' queries.

The ongoing challenge in this centre was the incompatibility of resident's needs and abilities in one house; this limited the potential to provide each resident with the optimal safe, quality home and service. The incompatibility was clearly identified and the provider's plan originated as a solution to this matter. It was identified that living together was not a long-term option for this group of residents. Their incompatibility manifested in behaviour of concern and risk that impacted on all parties. The provider had implemented strategies to prevent behaviour related incidents. These strategies were effective and adhered to by staff given that the frequency and intensity of incidents based on records seen had decreased. However, preventative strategies were highly dependent on avoidance and the segregation and separation of residents and their routines, such as different mealtimes, different times for getting up and leaving the house, the length of time spent out of the house. In addition residents could not all sit and engage together at the residents house meetings as this was certain to be a trigger to distress and behaviour. While necessary, management strategies placed restrictions and limitations on all residents. Staff described the residual tension and anxiety for residents and the different atmosphere in the house, positive or negative, dependent on the mix of residents present. The potential for anxiety, incidents and harm was ever present for as long as these residents lived together.

The effective identification and management of risk was also central to promoting resident safety in this context. The inspector saw that the person in charge maintained a suite of risk assessments relevant to the safety of each resident; some of these risks were specific to the resident such as a risk for falls or referred to the risk posed to them for harm and abuse due to their incompatibility as a group of

peers. Despite the controls implemented by the provider as described above the residual risk rating was moderate as residents continued to live together.

The provider has incrementally improved its arrangements to protect residents in the event of fire; emergency lighting and fire detection systems were installed in both houses. However, the provider has not completed works designed to contain fire and its products; the inspector was advised that the funding to complete these works regardless of what property they will be completed in is not available to the provider.

The inspector reviewed the existing fire safety arrangements and found that staff had completed fire safety training, staff and residents completed successful simulated evacuation drills; the fire detection system, emergency lighting and fire fighting equipment were inspected and tested at the prescribed intervals in 2018 and to date in 2019.

The provider had good arrangements for ensuring that residents enjoyed the best possible health. Frontline staff monitored and assessed resident well-being and liaised with nursing staff based on the main campus as and when necessary. Formal records with any changes made in care were exchanged between nursing staff and social care staff, for example following a medical appointment. Residents did have medical needs; the inspector found that they had access to the healthcare services that they required and staff were diligent in delivering their required care, for example in relation to specific fluid and dietary requirements.

Regulation 10: Communication

Residents did have communication differences but the inspector saw that staff and residents communicated effectively with each other, for example simply offering two items to choose one from. A clear distinction was drawn between respecting comprehension and any limitations there were on expressive ability.

Judgment: Compliant

Regulation 13: General welfare and development

Each resident had opportunity for new experiences, social participation, recreation, community inclusion and integration, training and meaningful employment. Access was determined by individual needs, abilities, interests and choices. Residents were supported to maintain and develop their relationships with peers, friends and family and to live ordinary and fulfilling lives in their community.

Judgment: Compliant

Regulation 18: Food and nutrition

Where residents had specific nutritional requirements the inspector found that they received the care and support that they needed for their ongoing well-being. This care was informed by access to the relevant healthcare professional. Staff worked with residents so that they understood their specific needs and consented to any limitations on their dietary choices. On a more general level residents were encouraged to make healthy lifestyle choices and body weight as an indicator of good health was regularly monitored.

Judgment: Compliant

Regulation 26: Risk management procedures

Risk management policies and procedures and risk assessments were in place for dealing with situations where resident and/or staff safety may have been compromised. Risks and their management were reviewed at a frequency based on their risk rating priority. The approach to risk management was individualised and supported both responsible risk and keeping residents safe from harm.

Judgment: Compliant

Regulation 28: Fire precautions

The provider has failed to complete infrastructural works for the containment of fire and its products.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

While the inspector was assured by the provider that each resident's plan was the subject of a multi-disciplinary review, this was not evident from the sample of plans

reviewed.

Judgment: Substantially compliant

Regulation 6: Health care

Staff assessed, planned for and monitored residents healthcare needs. Each resident has access to the range of healthcare services that they required.

Judgment: Compliant

Regulation 7: Positive behavioural support

The ongoing challenge in this centre was the identified incompatibility of resident's needs and abilities in one house. It was identified that living together was not a long-term option for this group of residents. Their incompatibility manifested in behaviour of concern and risk that impacted on all parties. Preventative strategies were highly dependent on avoidance and the segregation and separation of residents and their routines. While necessary, this placed restrictions and limitations on all residents. Staff spoken with and records seen described the residual tension, anxiety and risk for harm for residents as the potential for incidents was ever present for as long as these residents lived together. Therefore action was required by the provider to address this.

The provider was transitioning staff to a new programme of training on positive behavioural support including de-escalation and intervention techniques. Staff had not yet completed the full programme of training.

Judgment: Not compliant

Regulation 8: Protection

The provider was aware of its obligation to protect residents from all forms of abuse and harm and endeavoured to meet it's obligation in this regard, for example in the allocation of additional staffing, plans of support and safeguarding plans. However, the residual risk rating for harm was moderate as residents continued to live together; this is addressed above in Regulation 7.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were consulted with in a meaningful way in relation to the general operation of the service. For example residents were made aware of staffing and management changes; residents had access to senior management, were aware of the provider's plans for the service and of the delay in the progressing of those plans. The provider accepted and acknowledged how this impacted on resident's lives. Residents had access to and participated in advocacy services; residents participated in regular religious observance if this was important to them. The provision of support was individualised in that different levels of support were provided in accordance with individual needs and choices. Staff spoken with and records created by staff respected and promoted the privacy, dignity, rights and diversity of each resident.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially 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	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Group C - Community Residential Service Limerick OSV-0003941

Inspection ID: MON-0024978

Date of inspection: 01/07/2019

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. Annex for one resident will be completed by 30 March 2020. Funding for this building, including fire containment works has been identified by the service. 2. Following extensive engagement between Provider and HSE, the HSE has approved funding a mortgage to purchase a house to replace the current rental property. This will include provision for fire containment works. The provider has approval in principle for the mortgage, this will be finalised when the house for purchase is confirmed. The search for a suitable house has commenced. Completion date: 30.03.2020 3. Security of tenure:Engagement has continued. A verbal commitment is in place that residents can continue living in the current house until the new house is available. Completion date: 30.03.2020	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The Statement of Purpose has been updated to reflect the recent changes in governance. Staffing numbers, whole time equivalents, have been clarified. Complete 29.07.2019	

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
Policy on Communication update complete 30.04.2019
Safeguarding Policy- update complete 11.06.2019
Policy on Risk Management- update complete 25.07.2019

Policy re Finances will be updated by 30.09.2019
Policy on education and training will be updated by 30.09.2019

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. Funding for fire containment works as part of development of annex to one house has been identified. Work is scheduled to commence in late August/early Sept 2019.
Completion date: 30.03.2020

2. Funding for mortgage for a property to replace the existing rental house has been approved by HSE. Mortgage will include the costs associated with fire containment works.
Completion date: 30.03.2020

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:
Minutes of MDT review meetings held in 2018 issued to centre.
Complete: 24.07.2019

Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: All staff will have completed 2 day Managing Challenging Behaviour training by 25.10.2019. Day three training required for staff in one house will be complete 31.12.2019. Funding has been identified for the development of more suitable long term accommodation for one resident, completion date 30.03.2020.	

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 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	30/03/2020
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in	Not Compliant	Orange	30/03/2020

	place.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	29/07/2019
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	30/09/2019
Regulation 05(7)(a)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include any proposed changes to the personal plan.	Substantially Compliant	Yellow	24/07/2019
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 intervention techniques.	Not Compliant	Orange	31/12/2019
Regulation 7(5)(a)	The person in charge shall ensure that, where	Not Compliant	Orange	30/03/2020

	a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.			