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:	Tonyglassion Group Home
Name of provider:	Health Service Executive
Address of centre:	Monaghan
Type of inspection:	Short Notice Announced
Date of inspection:	28 January 2021
Centre ID:	OSV-0007820
Fieldwork ID:	MON-0030249

About the designated centre

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

Tonyglassion Group Home is a centre made up of one unit and is based in a rural setting in Co. Monaghan. It provides 24 hour residential supports for up to five residents who present with complex needs. The centre is comprised of a entrance hallway, two staff offices, four resident bedrooms (all of which have en-suite facilities), a central bathroom, two sitting rooms, a dining room, a kitchen, a utility room and a toilet. In a separate building in the garden to the rear of the centre there is an apartment which accommodates one resident. This building contains a kitchen/dining space, a main bathroom, store rooms, and a bedroom with en-suite facilities. The staff team is made up of a person in charge, staff nurses and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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
Thursday 28 January 2021	09:30hrs to 16:50hrs	Thomas Hogan	Lead

What residents told us and what inspectors observed

From what the residents told us and what the inspector observed, it was clear that residents were happy living in this centre and were having their basic care needs met, however, there were a number of areas identified which required improvement. These included the premises of the centre, the use of restrictive practices, staffing, respecting the personal rights of residents and oversight of the care and support being delivered. These are outlined in greater detail later in this report.

As previously mentioned, there were five residents living in this centre at the time of the inspection. The inspector met with four residents and also met with the person in charge, three staff members and spoke via telephone with two family members. In addition, the inspector received two resident questionnaires which were completed by residents with the support of staff members before the inspection. The residents experienced communication difficulties and some were able to tell the inspector about their experience living in the centre and that they felt safe. Staff members told the inspector that residents were happy in the centre and that they were safe. Staff members also explained that the centre was under resourced in terms of staffing levels and while there had been improvements in recent times that further improvements were required.

The resident questionnaires focused on a range of subjects including general satisfaction with the service being delivered, bedroom accommodation, food and mealtime experience, arrangements for visitors to the centre, personal rights, activities that residents engage in, staffing supports and complaints. Overall, residents who completed the questionnaires provided fair to positive feedback on these matters. The feedback received from family members also varied with some telling the inspector that the care and support being provided was very positive while some others described how there were improvements required in the management arrangements.

The centre was made up of one large detached house and an apartment in the garden space to the rear. While there was spacious rooms and modern facilities, the centre was found not to be laid out to meet the individual or collective needs of residents. For example, some residents had reduced mobility needs and one entrance way had not been modified to promote easy access to the building. Some areas of the centre were not in a good state of repair such as the exterior of the building - particularly the exterior walls of the apartment. In addition, the centre was not homely and presented in an institutionalised nature.

Throughout the time of the inspection residents were supported by staff members to engage in a range of activities including going to the local shop to buy a newspaper, going for a walk and to collect medication from a local pharmacy. Residents engaged in other activities at other times including attending to plants in a polytunnel in the centre's garden space, visiting families (prior to COVID-19

restrictions), attending day services and completing the grocery shopping with staff members.

While residents were unable to inform the inspector about how their personal rights were respected and upheld, there were a number of observations which indicated that significant improvement was required in this area. There were high levels of restrictive practices in place throughout the centre and the justification for their use was not clear for the registered provider. The inspector found that they were in place to support some residents but were having a negative impact on other residents. The restrictive practices included locked doors, all kitchen cabinet doors locked, restricted access to running water, bathrooms locked, use of audio monitors and locked storage presses. As a result the inspector found that registered provider had not appropriately considered the compatibility of residents. The dignity of some residents was impacted by the high levels of use of restrictive practices in the centre.

The inspector found that while there was some promotion of choice and decision making for residents, overall, there was a limited approach to this. For example, residents attended a monthly residents' meeting where decisions were made around menu and activity planning, however, residents were unable to choose items from kitchen cupboards or access snacks without the support of staff members. Some residents were unable to access drinking water without staff as water supply was restricted for them.

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 on the quality and safety of the service being delivered.

Capacity and capability

Given the number of non-compliances identified during the course of this inspection, it was clear that significant improvements were required in the development and implementation of effective management systems to ensure appropriate oversight and delivery of services which were of a good standard, consistent and appropriate to the needs of residents.

The inspector met with the person in charge at the time of the inspection. They had recently been appointed to the role and took up the position in August 2020. The person in charge was employed in a full-time capacity in the centre and met the requirements of the regulations relating to management experience and holding an appropriate qualification in health or social care management.

A review of the staff rosters found that while there was continuity of care and support in the centre, overall, there was insufficient numbers of staff members employed to meet the assessed needs of residents. Both staff and family members

informed the inspector that the centre was not adequately resourced in this regard. Due to the closure of day services as a result of the COVID-19 pandemic, the inspector observed that there were increased numbers of residents in the care of the staff in the centre during day time hours and there was no increase in staff allocation to support residents during these times. This resulted in reduced activity levels for residents and fewer opportunities for one-to-one engagement with staff members. A review of a sample of staff files found that some information such as dates of commencement, full employment history and signed references were not maintained by the registered provider as required by the regulations.

A review of training records found that all staff had completed the training outlined as required by the registered provider. The person in charge and staff team had undertaken additional training in areas such as report writing, management of epilepsy, health and safety, communication and complaints management. There were appropriate arrangements in place for the supervision of the staff team and regular one-to-one supervision meetings were taking place with all staff members.

A sample of incident, accident and near miss records maintained in the centre were reviewed by the inspector who found that required notification of incidents to the Chief Inspector had been completed as per the regulations.

The inspector completed a review of the arrangements for the management of complaints and found that the registered provider had established and implemented an effective complaints management system. There was a complaints policy in place and there were easy read complaints procedures on display. A number of complaints had been made in the time since the last inspection and when reviewed by the inspector were found to have been appropriately followed up on by the registered provider.

Regulation 14: Persons in charge

The person in charge was found to be employed in a full-time capacity and met the requirements outlined in regulations.

Judgment: Compliant

Regulation 15: Staffing

The inspector found that the centre was not adequately resourced in terms of numbers of staff members employed. Some information required to be maintained on staff files and outlined in Schedule 2 of the regulations was not available.

Judgment: Not compliant

Regulation 16: Training and staff development

There was evidence available to demonstrated that training identified as mandatory by the provider had been completed by all staff members. In addition, a range of non-mandatory training had also been completed by the staff team.

Judgment: Compliant

Regulation 23: Governance and management

The centre was not adequately resourced to ensure the effective delivery of care and support to residents in accordance with the statement of purpose. There was a need for the development of management systems to ensure that services provided were appropriate to the needs of residents and effectively monitored.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspector reviewed a sample of incident, accident and near miss records maintained in the centre and found that required notification of incidents to the Chief Inspector had been completed as per the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The inspector found that the registered provider had established and implemented effective systems to address or resolve issues raised by residents and their representatives.

Judgment: Compliant

Quality and safety

Overall, the inspector found that services were not being provided in line with a person-centred or human rights based approach. There were some clear examples of institutionalised care practices taking place which required review by the registered provider. These included the significant use of restrictive practices in the centre, the manner in which residents were supported to exercise their personal rights, and the condition of the premises of the centre.

As previously mentioned, the premises of the centre were not designed or laid out to meet the needs of the residents. In certain parts the centre was not kept in a good state of repair including floor coverings in certain areas, some bedroom walls needing painting, and external walls needing plastering and painting. Other concerns identified included an en-suite bathroom in a resident's bedroom having no door fitted. Additionally, a resident who was using a wheelchair at the time of the inspection could not access the centre through one of the entrance and exit routes as there was an absence of accessible ramps at that door. Overall, the centre was not presented in a homely fashion and had an institutional type presentation.

A review of the measures taken by the registered provider to protect residents against infection was completed by the inspector. The registered provider had taken appropriate action to prevent or minimise the occurrence of healthcare-associated infections in the centre including COVID-19. Staff members had access to stocks of personal protective equipment (PPE) in the centre and there were systems in place for stock control and ordering. There was a COVID-19 information folder available in the centre, which was updated with relevant policies, procedures, guidance and correspondence. These included a response plan in the event that an outbreak were to occur in the centre.

Fire precaution measures were reviewed by the inspector who found that there was a fire alarm and detection system in place along with appropriate emergency lighting. There were personal emergency evacuation plans in place for each resident which clearly outlined the individual supports required in the event of a fire or similar emergency. Regular fire drills were taking place in the centre and records demonstrated that residents and staff could evacuate the centre without difficulty in a reasonable time frame. While there were some fire containment measures in place, these did not include a self-closing device on the utility room fire door.

A review of the measures in place to support residents with behaviours of concern was completed by the inspector. Overall, the inspector found that there was clear guidance in place for staff through the use of behaviour support plans which were reviewed on a regular basis. However, the inspector found that there was significant use of restrictive practices in the centre and in some cases the registered provider had failed to recognise or identify some of those practices which were in place. While some restrictions in use may have been required to support residents, there was an overall absence of clear justification for their use or the consideration of the least restrictive alternative for the shortest duration of time. For example, some

residents were restricted in their access to running water and drinking water which was explained to be as as result of medical reasons. When the medical recommendation for the amount of daily water or fluid intake was reviewed by the inspector it was found that residents regularly did not receive the maximum amount prescribed. On some occasions residents received as little as 500mls in a 24 hour period. While the inspector recognised that there was a possibility that poor recording practices within the centre led to partial recording of fluid intake for some residents, there was clear evidence to demonstrate limited oversight of the use of restrictive practices and that the least restrictive alternatives were not being considered or used for the least amount of time necessary.

The inspector found that residents were appropriately protected and safeguarded from experiencing abuse in the centre. The person in charge and staff team were knowledgeable of the different types of abuse and the actions that are required to be taken in response to witnessing or suspecting incidents of a safeguarding nature. A review of incident and accident data found that while a number of incidents of a safeguarding nature had occurred in the centre, these were managed in accordance with local and national policy.

The arrangements to support residents with their rights were reviewed by the inspector. Overall, the inspector found that centre was not operated in a manner which respected the dignity or disabilities of some residents due to the application of restrictive practices. For example, while restrictions were applied to manage the behaviours of concern of some residents, others were negatively impacted by the use of those restrictions. There was no input from independent advocacy services despite the high levels of restrictive practices in the centre and there was clear evidence to demonstrate that the freedom to exercise choice and control was limited for some residents. The registered provider had failed to appropriately assess the compatibility of residents who shared the accommodation of the centre and to ensure that the living arrangements were suitable.

Regulation 17: Premises

The centre was not fully accessible for some residents who were availing of its services. There was a need for improvements in the upkeep and maintenance of some areas of the centre.

Judgment: Not compliant

Regulation 27: Protection against infection

The registered provider had developed policies, procedures and guidelines for use during the COVID-19 pandemic to prevent or minimise the occurrence of the virus in

the centre.

Judgment: Compliant

Regulation 28: Fire precautions

At least one fire containment door did not have a self-closing device fitted to it as required to ensure its effectiveness in the event of a fire in that area of the centre.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Restrictive practices in use in the centre had not been applied in line with national policy on restraint. Justification for the use of some restrictions was not clear on the part of the registered provider. The use of restrictive practices, in some cases, was not being monitored and as a result the inspector found that there was limited oversight of their use. The least restrictive alternative was not considered and restrictions were not being used for the shortest duration necessary.

Judgment: Not compliant

Regulation 8: Protection

The inspector found that the provider had taken appropriate action to safeguard residents from experiencing abusive incidents in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

The rights of residents were not promoted and were not actively considered in decisions taken by the registered provider. This was particularly evident in the consideration of compatibility of residents and in the use of restrictive practices. While there was access to independent advocacy services, there was no active involvement from such services despite the significant restrictions which residents experienced.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Tonyglassion Group Home OSV-0007820

Inspection ID: MON-0030249

Date of inspection: 28/01/2021

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: In order to meet compliance with Regulation 15: Staffing, the following actions have been undertaken: • During continued temporary closure of Day Services, an additional staff has been allocated to the centre to ensure activity levels for residents and opportunities for 1-1 engagement is realised. • A full review of all staff personnel files has been completed by the Person in Charge who has ensured all information in relation to schedule 2 is now available in staff files. • A full review of the roster has been completed by the Person in Charge to include the use of key codes used to identify relevant hours associated with identified key code.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: In order to meet compliance with Regulation 23: Governance and Management the following actions have been undertaken: Management systems in place in the centre have been reviewed to ensure the needs of residents are appropriately met and are monitored on a regular basis. • Ongoing monitoring of the centre's Quality Improvement Plan by the Registered Provider and the General Managers Office. • Bi monthly meetings with the Registered Provider/Director of Nursing and Person in	

Charge.
• Monthly onsite senior management visits to the centre.
• An agreed schedule of audit completed monthly/3 monthly to include:
· Person Centered Planning
· Medication Management
· Infection Control/Hygiene
· Complaints
· Incident Management
• Weekly monitoring of incidents and restrictive practices by the Clinical Nurse Specialist in Behavioral Management.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
In order to meet compliance with Regulation 17 Premises, the following actions have been undertaken:
• Person in Charge has sourced contractors for completion of painting of bedroom walls and plastering of external walls. This work will be completed by 26/02/21
• Person in Charge has sourced contractors for painting of outside of main house and apartment and will be completed by end of May 2021.
• Occupational Therapist has completed assessment of exit routes for ramp access on 19/02/2021. A temporary ramp has been ordered by the Occupational Therapist and will be installed on the 16th April 2021.
• Floor covering has been replaced in one resident's bedroom on the 23/02/21.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
In order to meet compliance with Regulation 28 Fire Regulations, the following actions have been undertaken:
• Person In Charge has ensured that self-closing device has been installed on utility room door on 03/02/21.

Regulation 7: Positive behavioural	Not Compliant

support	

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
In order to meet compliance with Regulation 7 Positive Behavioural Support, the following actions have been undertaken:
• Multi-disciplinary meeting attended by Service Provider, Senior Clinical Psychologist, Director of Nursing, Assistant Director of Nursing, Clinical Nurse Specialist, Clinical Nurse Manager 3 and Person In Charge held on 09/02/2021.

1. Systematic review of all restrictive practices has been conducted. The following restrictive practices have been reviewed and alternative measures implemented.
• Larger Televisions have been installed at eye level without protective Perspex screen.
• In conjunction with GP consultation, water restriction for 1 resident has been removed and is being closely monitored.
• Kitchen Door lock has been removed and the number of kitchen press locks reduced to a minimum of 3 to include sharps press, pantry press and fridge to ensure safety of residents.
• Hot Press Door and Storage Room Door lock have been removed.

2. All restrictive practices will be reviewed and monitored by the Person In Charge with Clinical Nurse Specialist and Senior Management Team informed on a weekly basis to ensure that restrictive practices are being used for the shortest duration necessary and that the least restrictive alternative has been considered.
3. Person In Charge has completed a full review of all resident's risk assessments and has ensured a rationale is included for management controls to ensure resident's health and safety.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
n order to meet compliance with Regulation 9 Residents Rights, the following actions have been undertaken:
• Multi-disciplinary meeting attended by Registered Provider, Senior Clinical Psychologist, Director of Nursing, Assistant Director of Nursing, Clinical Nurse Specialist, Clinical Nurse Manager 3 and Person In Charge held on 09/02/2021.
• Systematic review of all restrictive practices has been conducted and the following restrictive practices have been reviewed and the following alternative measures implemented. These will be reviewed in relation to effectiveness and impact and consideration to safety of all residents.
1. Larger Televisions have been installed at eye level without protective Perspex screen.
2. In conjunction with GP consultation, water restriction for 1 resident has been removed and is being closely monitored.
3. Kitchen Door lock has been removed and the number of kitchen press locks reduced

to a minimum of 3 to include sharps press, pantry press and fridge to ensure safety of residents.
4. Hot Press Door and Storage Room Door lock have been removed.
• All restrictive practices will be reviewed and monitored by Person In Charge and Clinical Nurse Specialist and Senior Management Team informed on a weekly basis to ensure that restrictive practices are being used for the shortest duration necessary and the least restrictive alternative has been considered.
• Person In Charge has ensured through Open Disclosure that all residents and resident representatives have been informed of all restrictive practices currently being used within the centre.
• Person In Charge has made contact with Advocacy Services and an initial Advocacy session was conducted on the 23/02/2021. These sessions will be ongoing for residents within the centre.
• The Registered Provider has assessed the compatibility of residents who share accommodation in the center. Plans have been developed for a new extension to provide accommodation for one resident which has the potential to further decrease the use of restrictive practices within the center. This is due to be completed in October 2021.

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	01/03/2021
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	31/03/2021
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet	Not Compliant	Orange	31/10/2021

	the aims and objectives of the service and the number and needs of residents.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	31/05/2021
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	26/02/2021
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Not Compliant	Orange	16/04/2021
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre	Not Compliant	Orange	01/03/2021

	is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	09/02/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	03/02/2021
Regulation 07(4)	The registered provider shall 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.	Not Compliant	Orange	09/02/2021
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour	Not Compliant	Orange	09/02/2021

	necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.			
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	09/02/2021
Regulation 09(1)	The registered provider shall ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.	Not Compliant	Orange	23/02/2021
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.	Not Compliant	Orange	26/02/2021

Regulation 09(2)(d)	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 access to advocacy services and information about his or her rights.	Not Compliant	Orange	23/02/2021
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.	Not Compliant	Orange	31/10/2021