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:	Seacrest Services
Name of provider:	Ability West
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	25 July 2022
Centre ID:	OSV-0001509
Fieldwork ID:	MON-0037487

About the designated centre

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

Seacrest Services supports seven male and female adults with a diagnosis of intellectual disability, who require a level of support ranging from minimum to high, and which may include co-morbidity. This service is a combination of residential and respite care. Respite care is provided on the basis of planned, recurrent, short stay placements. Seacrest is a two-storey house in an urban residential area. The house is centrally located and is close to amenities such as shops, restaurants, public transport, pharmacist and a church. All residents in the centre have their own bedrooms. The physical design of the building renders parts of it unsuitable for use by individuals with complex mobility needs or wheelchair users, although some residents with physical disabilities can be accommodated on the ground floor. Residents are supported by a staff team that includes the person in charge, social care workers and care assistants. Staff are based in the centre whenever residents are present, including at night time.

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 (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
Monday 25 July 2022	11:30hrs to 16:30hrs	Aonghus Hourihane	Lead

What residents told us and what inspectors observed

The inspection was carried out to assess the provider's compliance with specific regulations. The Chief Inspector had received information which raised specific concerns about staffing levels, restrictive practices and the overall governance within the centre.

Seacrest is a large two-storey house located on the outskirts of a city. The home is registered for seven residents but on the day of the inspection there was five residents and one of these only accessed the service on a part-time basis. The resident population had a complex array of needs with two residents using wheelchairs on a full-time basis and most residents having different health and social care needs that required the provider to be consistently reviewing the service it offered to ensure that the care and support needs of residents were fully met.

The inspection was facilitated by the person in charge who was working throughout the inspection giving care and support to the residents. The person in charge had recently been appointed and was in the process of getting to know the service and the residents.

The five residents were present on the morning of the inspection. One resident was preparing to return to family and the inspector met with them briefly. The inspector met and interacted with the other residents throughout the inspection. The residents all received an integrated day service in the centre or were retired and enjoyed a slower pace to life.

The centre was generally in good condition, the kitchen area had been recently renovated and it was observed that there was ample room for the residents to socialise. The person in charge showed the inspector the garden area which was fully accessible for all residents and had recently been renovated with the assistance from a local business. The area was welcoming and residents were reported to enjoy socialising there especially in the nice weather. Other parts of the centre did need improvement, given the varied needs of the residents there was a requirement for various different equipment and this was stored in the hallway, living room and an unused bedroom. There was also personal items such as files and clothes from residents both past and present that were inappropriately and insecurely stored in an unlocked room.

The staff and person in charge were able to give significant detail about what life was like in the centre for the residents. The residents benefited from drama and music one day a week. There was also reflexology offered on a different day and these all took place in the centre. One resident had a daily visit to a local shop and they may also have coffee while out on an open green area if the weather was nice. The same resident also enjoyed attending their local pub for a recreational pint. The residents as a group visited a local hotel for food and beverages. There was one night a week when all residents got to have food from a local takeaway. Family

visiting was encouraged and there were no restrictions presently, it was noted that one resident only used the service on a part-time basis and spent the rest of the time with family. Another resident had regular contact with family and spent overnights with them.

The staff spoken with as part of this inspection all spoke kindly and positively about the residents. They were observed to be gentle and respectful in their interactions with the residents and displayed good knowledge of their needs.

While the residents appeared to enjoy a decent quality of life this was very much dependent on the levels of staffing within the centre. On the day of the inspection the person in charge confirmed that a particular resident could not be brought out of the centre without having to bring another resident regardless of their wish or desire to go out. If the resident did go out this would mean that there was only one staff member to meet the needs of the other residents and during this time certain basic care tasks that required two people could not be performed if needed. The current arrangements within the centre were not conducive to protecting and promoting the rights of residents to exercise choice within the centre and over their own lives.

The next two sections of the report outline 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 residents lives.

Capacity and capability

The provider had not ensured there were effective management systems in place to ensure that the service provided was safe, consistent and appropriate ro the needs of the residents. There was also significant issues with the provider's ability to evidence compliance with the regulations through the information systems available on the day of the inspection.

The provider had in the past month appointed a full-time person in charge. The person in charge was getting to the know the service and residents. They were fully committed to ensuring that the service became compliant and recognised the challenges that they faced to do this. Many of the issues with compliance had been identified by the person in charge since they started working in the centre. The person in charge worked as part of the staffing rota with a total of 12 hours dedicated to management duties. Given the significant deficits identified in this inspection and generally recognised by the provider, they needed to satisfy themselves that the person in charge has the time and resources to address the issues within the centre in line with the regulation.

The staffing arrangements within the centre needed a comprehensive review. From discussions with the person in charge and staff as well as a review of the planned and actual staff rota it was clear that there were multiple weekdays when staffing

levels were not at the level the provider had prescribed. The inspector was also unable to be fully satisfied from the records produced that the staffing levels overall were in line with the assessed needs of the residents. Two residents used wheelchairs and required the assistance of two staff with all transitions, another resident was a high risk for falls as well as assistance with personal care. The residents were ageing and their needs naturally changing but there was insufficient evidence that the provider's own governance and management systems were picking up these issues and responding to them.

The provider's record keeping was not in line with regulations. The records for the residents and the centre generally were not maintained. An active file for one resident was reviewed, it contained a safeguarding plan at the front from 2017 with no explanation or guidance as to it's current validity. The contents generally of the file was not in line with Schedule 3 of the regulations and much of the information was outdated and largely irrelevant.

The provider was completing the six monthly audits of the service, the last one in December 2021. These were announced visits and so not in line with regulations. There was evidence on documentation shown that the overdue six monthly audit was being planned for early August 2022 and this again was announced and so not in line with the regulations. The annual review took place in January 2022 and a quality improvement plan was developed. The time frames for actions on the plan were not met with many of the actions not even started such as a review of restrictive practices which was due by 30 June 2022.

Regulation 14: Persons in charge

The provider had recently appointed a new person in charge. The person in charge has extensive experience working in the area of social care and nursing. The person in charge works as part of the staff rota within the centre and is assigned 12 protected hours per week for management duties . Given the extensive levels of non-compliance's during this inspection the provider needs to ensure that the person in charge has the time to ensure effective governance, operational management and administration of the designated centre.

Judgment: Substantially compliant

Regulation 15: Staffing

The provider had determined that there were three staff needed in the afternoons and evenings within the designated centre. On the day of the inspection there were only two staff to cover this shift. The rosters were reviewed for the previous month and there were multiple week days when the provider was not able to ensure that

three staff were on the roster. The person in charge confirmed this to the inspector and the senior manager explained that staffing was the number one issue for the provider. The provider was unable to evidence during the inspection that the staffing levels in the centre were appropriate to the number and assessed needs of the residents. The planned and actual staff rota was not properly maintained as it was not possible to always verify the information on the rotas.

Judgment: Not compliant

Regulation 21: Records

Overall record keeping in the designated centre was poor. The main office was disorganised and records were poorly maintained and not assessable. There was a vacant unlocked bedroom and this room contained private records for both current residents and others. The provider did not ensure that all records as specified in Schedule 3 and Schedule 4 of the regulations were maintained and available for inspection.

Judgment: Not compliant

Regulation 23: Governance and management

The provider did not ensure that the designated centre was resourced to ensure the effective delivery of care and support to the residents. The provider acknowledged that staffing was the primary concern within the centre. The provider had completed an annual review but the unannounced visits on a six monthly basis were in fact announced. The management systems and overall governance within the centre had not identified the issues as outlined in this inspection report. The provider did not have adequate out of hours on-call systems available to the centre for week days.

Judgment: Not compliant

Quality and safety

The challenges with record-keeping in the centre raised issues with evidencing and verifying the quality and safety of the service on offer. The provider committed to a restrictive practice review by June 30th 2022 in their own quality improvement plan and this had not commenced. It was unclear from a review of the paperwork available, discussions with the person in charge and the senior manager that all the

restrictive practices were recorded, notified and in line with regulations and national policy.

The centre's risk management procedure did not capture the issues pertaining to staffing, there was therefore no control measures available to ensure that the service was kept safe at all times and that the issues identified had the least possible impact on the quality of resident lives. The individual risk management plan for one resident that was reviewed in February 2022 did not correlate with the practice as reported by a staff member in the centre in relation to use of a comfort chair and lap belt.

The majority of residents in this service had high and complex needs. There was some evidence that care plans were reviewed and each resident had their own key worker. The provider was very clear that the key worker had responsibility to ensure that reviews took place and files were updated. It was not possible to fully evidence from reading resident files and in discussions with management what the staffing needs of each resident were, if this forms part of the annual review and how this fed into the overall resources for the centre.

The provider was ensuring that residents had access to a variety of healthcare professionals and was fully committed to responding to the changing needs of the residents. The appointment of a person in charge with a healthcare background should add strength in time to the assessment of the resident's needs.

There had been two safeguarding notifications in recent months and the provider has a safeguarding plan in place in relation to the resident. The provider confirmed that they responded to these incidents in line with their own policy and will submit confirmation to HIQA by August 22nd 2022.

Regulation 26: Risk management procedures

The provider's risk management policy for the centre did not reference the challenges faced by the provider with the gaps that continue to occur on the staff rota on a regular basis. There were a lack of control measures to ensure the quality of life and safety of the residents in the centre. The provider did not have an adequate system to respond to emergencies as evidenced by a resident having to get an ambulance to hospital alone as the provider could not provide staff to attend with them. This happened in the months leading up to the inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The residents in the centre had individual assessments and care plans but it was not

apparent from the records available that these were comprehensively updated in line with the regulations to reflect changes in need and circumstances. There was little evidence made available on this inspection as to how the individual care needs of residents interacted with the providers responsibilities to provide resources and to ensure that the centre was in a position to meet the needs of the residents. The file of one resident reviewed did not contain the required review within the past year as required by the regulations and the provider was unable to confirm when the review had last taken place.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The risk assessment for one resident stated there was a restrictive practice in place with the use of a lap belt on a comfort chair during physiotherapy sessions only. The restrictive practice was not notified to the chief inspector and controls sheets on the residents file were blank. One staff member stated that the chair was never used by staff with the resident as it would constitute a restrictive practice that was not approved, they further stated that the chair didn't belong to the particular resident. Another staff member confirmed that the chair and belt were used for medical reasons to ensure that the resident had his feet propped up on occasions. The inspector was unable to confirm from speaking with the person in charge, the senior manager and a review of the records available that certain restrictive practices were applied in accordance with national policy and evidence based practice.

Judgment: Not compliant

Regulation 8: Protection

There were two safeguarding notifications made to the Chief Inspector in recent months. Prior to this inspection the provider was requested to provide further information on these safeguarding matters by August 22nd 2022. The inspector reviewed the notifications as part of this inspection and the provider confirmed that they had followed their own policy and this was in line with national guidance on safeguarding vulnerable adults.

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Substantially compliant
Regulation 15: Staffing	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Seacrest Services OSV-0001509

Inspection ID: MON-0037487

Date of inspection: 25/07/2022

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 14: Persons in charge	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: Weekly scheduled meetings have commenced from 03/08/2022 with the Person in Charge and the Person Participating in Management; the agenda for these meetings is based on the areas of non-compliance following the inspection and any additional areas identified that required support. The staffing roster has been reviewed to accommodate additional hours for the Person in Charge to ensure that she has the time to ensure effective governance, operational management and administration of the designated centre.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The staffing roster will be reviewed further on completion of the centre assessment of needs, based on each person's individual assessment of needs; this has commenced on the 11/08/2022, and to be completed by 05/09/2022. In addition, a further detailed assessment in terms of clinical needs is being commissioned for each resident, and this will feed into the individual assessment of needs and centre assessment of needs. This will be completed by 10/09/2022. A formal planned staffing roster is now in place, on the basis of current whole time equivalent budget and current needs of service users, as detailed in their records of health and social care needs. Additional staffing has been allocated during the weekdays to facilitate this. Therefore, staffing levels are in place to ensure the allocated whole	

time equivalent allocation is available to residents. Where annual leave or unexpected absence requires cover there are a number of relief staff available to the service. Staff who do not work whole time contracts have also indicated they will be available to work additional shifts to their contract.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
The office in the designated centre has been reorganised, files and records are organised for ease of access.

A review has commenced in relation to records to be archived, some work has already been completed on this in relation to records stored in vacant bedroom. In the meantime, the records for archival are stored in a secure locked environment. This work is due to be completed on 30/09/2022.

A review has commenced with regard to Schedule 3 records and all other residents health and social care records to ensure that they are uptodate and current. This is being completed on a phased basis by each key worker, overseen by the Person in Charge. This work is due to be completed on 10/09/2022.

A review has commenced with regard to Schedule 4 records to ensure that they are all uptodate and current. This work is due to be completed on 31/08/2022.

Each resident's file will have a records review audit tool to be completed by staff members, and an audit of this will form part of the Person in Charge's set of audit tools, with at least monthly audits. This will commence from 15/09/2022.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Work on completion of the centre assessment of needs and review of each person's individual assessment of needs, has commenced on 11/08/2022, This work will direct the overall review of staffing resources and their adequacy in meeting the assessed needs of the residents. This will be completed by 05/09/2022. In addition, a further detailed assessment in terms of clinical needs is being commissioned for each resident, and this will feed into the individual assessment of needs and centre assessment of needs. This

will be completed by 10/09/2022.

A formal planned staffing roster is now in place, on the basis on current whole time equivalent budget and current needs of service users, as detailed in their records of health and social care needs. Therefore, staffing levels are in place to ensure the allocated whole time equivalent allocation is available to residents. The staffing roster will be reviewed further on completion of the centre assessment of needs, based on each person's individual assessment of needs.

An unannounced Provider led audit took place in Seacrest service on the 05/08/2022, from which a report has been issued to the Person in Charge.

The current on call system which is included in procedures is that Assistant Directors of Client Services are on call for out of hours Monday to Friday for their respective services and on call rota is in place for weekends. Once the current recruitment process within Client services is complete, this will enhance the existing procedure. This will be completed by 30/12/2022.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The Centre risk register has been reviewed and amended to reflect current challenges in the designated centre, the availability of staffing resources has been identified as the number 1 risk, followed by changing needs of the residents. Control measures are in place, for example, for the number 1 risk, a number of staff have been identified as relief staff who are familiar with the designated centre; and for number 2, risk the centre assessment of needs and individual assessment of needs are being completed to provide a clearer picture for service provision. The risk register and associated risk assessments were completed on 19/08/2022.

The risk register forms part of the weekly scheduled sessions between the Person in Charge and the Person Participating in Management.

In relation to on call system which is included in procedure, is that "Assistant Directors of Client services are on call out of hours Monday to Friday for their respective services and on call rota is in place for weekends. "Once the current recruitment process within client services is completed, this will enhance the existing procedure. December 30th 2022.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Work on completion of the centre assessment of needs and review of each person's individual assessment of needs, has commenced on 11/08/2022, This work will direct the overall review of staffing resources and their adequacy in meeting the assessed needs of the residents. This will be completed by 05/09/2022.

In addition, a further detailed assessment in terms of clinical needs is being commissioned for each resident, and this will feed into the individual assessment of needs and centre assessment of needs. This will be completed by 10/09/2022.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
A review of the restrictive practices within the designated centre has commenced by the Person in Charge, overseen by the Person Participating in Management. This will include a review of restrictive practice documentation including risk assessments, protocols restrictive practice logs, and staff signature to confirm the duration of the restriction practice in use. The completion date for this is 31/08/2022.

An independent review of the environment to identify any restrictive practices will be completed by the 05/09/2022.

In relation to one specific situation, following the review of a comfort chair which supports a resident to elevate his feet while enjoying reflexology, to ensure the residents safety, should the use of the lap belt be required, an application to Restrictive Practices Committee will be made. This restriction, will be for the shortest duration possible, in line with national policy.

Staff training is being organised in relation to rights promotion/restrictive practices for the staff team, to be completed by 15/09/2022.

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 14(2)	The post of person in charge shall be full-time and shall require the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.	Substantially Compliant	Yellow	03/08/2022
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	10/09/2022
Regulation 15(3)	The registered	Not Compliant	Orange	10/09/2022

	provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.			
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	10/09/2022
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	31/08/2022
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	10/09/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	30/12/2022

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
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	05/08/2022
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	19/08/2022
Regulation	The registered	Not Compliant	Orange	19/08/2022

26(1)(b)	provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the risks identified.			
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Not Compliant	Orange	19/08/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	30/09/2022
Regulation 05(1)(b)	The person in charge shall	Not Compliant	Orange	10/09/2022

	ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	10/09/2022
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	15/09/2022
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour	Not Compliant	Orange	05/09/2022

	necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.			